DOCUMENT RESUME

ED 445 306 CG 030 371

TITLE	Conduct and Behavior Problems: Intervention and Resources for School-Aged Youth. An Introductory Packet.
INSTITUTION	California Univ., Los Angeles. Center for Mental Health in Schools.
SPONS AGENCY	Health Resources and Services Administration (DHHS/PHS), Rockville, MD. Bureau of Maternal and Child Health and Resources Development.
PUB DATE	1999-03-00
NOTE	133p.
PUB TYPE	Guides - Non-Classroom (055)
EDRS PRICE	MF01/PC06 Plus Postage.
DESCRIPTORS	Antisocial Behavior; *Behavior Problems; *Children; Educational Environment; Elementary Education; *Mental Health; *Resources; *School Psychologists; *Student Problems

ABSTRACT

This introductory packet contains materials to help the school mental health worker deal with conduct and behavior problems among students. The range of such problems is described, using fact sheets and the classification scheme from the American Pediatric Association. Selections from a variety of sources discuss differences in the interventions needed with respect to variations in the degree of problem manifested. These differences include the exploration of environmental accommodations, behavioral strategies, and medication. The packet contains the following sections: (1) "Classifying Conduct and Behavior Problems: Keeping the Environment in Perspective as a Cause of Commonly Identified Psychological Problems"; (2) "The Broad Continuum of Conduct and Behavior Problems"; (3) "A Quick Overview of Some Basic Resources"; (4) "Interventions for Conduct and Behavior Problems"; (5) "A Few Resource Aids"; and (6) "Keeping Conduct and Behavior Problems in Broad Perspective." The list of resources contains agencies and Web sites focusing on these concerns. A list of the publications of the Center for Mental Health in Schools is attached. (SLD)

Reproductions supplied by EDRS are the best that can be made
from the original document.

ED 445 306

Mental Health in Schools
Center
Training and Technical Assistance

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION
CENTER (ERIC)

☐ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

- Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

*From the Center's Clearinghouse ...**

An introductory packet on

Conduct and Behavior Problems: Intervention and Resources for School Aged Youth

This Center is co-directed by Howard Adelman and Linda Taylor and operates under the auspice of the School Mental Health Project, Dept. of Psychology, UCLA.

Address: Center for Mental Health in Schools, Box 951563, Los Angeles, CA 90095-1563
Phone: (310) 825-3634 Fax: (310) 206-8716; E-mail: smhp@ucla.edu Website: http://smhp.psych.ucla.edu

Support comes in part from the Department of Health and Human Services, Public Health Service, Health Resources and Services Administration, Maternal and Child Health Bureau, Office of Adolescent Health.

U.S. Department of Health & Human Services
Public Health Service
HRSA
Health Resources & Services Administration
Maternal & Child Health Bureau
Office of Adolescent Health

3/99

BEST COPY AVAILABLE

CG030371

Mental Health in Schools
Center
Training and Technical Assistance

UCLA CENTER FOR MENTAL HEALTH IN SCHOOLS*

Under the auspices of the School Mental Health Project in the Department of Psychology at UCLA, our center approaches mental health and psychosocial concerns from the broad perspective of addressing barriers to learning and promoting healthy development. Specific attention is given policies and strategies that can counter fragmentation and enhance collaboration between school and community programs.

MISSION: ***To improve outcomes for young people by enhancing policies, programs, and practices relevant to mental health in schools.***

Through collaboration, the center will

- enhance practitioner roles, functions and competence
- interface with systemic reform movements to strengthen mental health in schools
- assist localities in building and maintaining their own infrastructure for training, support, and continuing education that fosters integration of mental health in schools

Consultation Cadre ***Clearinghouse***

Newsletter ***National & Regional Meetings***

Electronic Networking

Guidebooks ***Policy Analyses***

Co-directors: Howard Adelman and Linda Taylor
Address: UCLA, Dept. of Psychology, 405 Hilgard Ave., Los Angeles, CA 90095-1563.
Phone: (310) 825-3634 FAX: (310) 206-8716 E-mail: smhp@ucla.edu
Website: http://smhp.psych.ucla.edu/

---

*In 1996, two national training and technical assistance centers focused on mental health in schools were established with partial support from the U.S. Department of Health and Human Services, Public Health Service, Health Resources and Services Administration, Maternal and Child Health Bureau, Office of Adolescent Health. As indicated, one center is located at UCLA; the other is at the University of Maryland at Baltimore and can be contacted toll free at 1-(888) 706-0980.

U.S. Department of Health & Human Services
Public Health Service
HRSA
Health Resources & Services Administration
Maternal & Child Health Bureau
Office of Adolescent Health

What is the Center's Clearinghouse?

The scope of the Center's Clearinghouse reflects the School Mental Health Project's mission -- to enhance the ability of schools and their surrounding communities to address mental health and psychosocial barriers to student learning and promote healthy development. Those of you working so hard to address these concerns need ready access to resource materials. The Center's Clearinghouse is your link to specialized resources, materials, and information. The staff supplements, compiles, and disseminates resources on topics fundamental to our mission. As we identify what is available across the country, we are building systems to connect you with a wide variety of resources. Whether your focus is on an individual, a family, a classroom, a school, or a school system, we intend to be of service to you. Our evolving catalogue is available on request; eventually it will be accessible electronically over the Internet.

What kinds of resources, materials, and information are available?

We can provide or direct you to a variety of resources, materials, and information that we have categorized under three areas of concern:

- Specific psychosocial problems
- Programs and processes
- System and policy concerns

Among the various ways we package resources are our *Introductory Packets, Resource Aid Packets, special reports, guidebooks*, and *continuing education units.* These encompass overview discussions of major topics, descriptions of model programs, references to publications, access information to other relevant centers, organizations, advocacy groups, and Internet links, and specific tools that can guide and assist with training activity and student/family interventions (such as outlines, checklists, instruments, and other resources that can be copied and used as information handouts and aids for practice).

Accessing the Clearinghouse

• E-mail us at	**smhp@ucla.edu**
• FAX us at	(310) 206-8716
• Phone	(310) 825-3634
• Write	School Mental Health Project/Center for Mental Health in Schools. Dept. of Psychology, Los Angeles, CA 90095-1563

Check out recent additions to the Clearinghouse on our Web site
http://smhp.psych.ucla.edu

All materials from the Center's Clearinghouse are available for a minimal fee to cover the cost of copying, handling, and postage. Eventually, we plan to have some of this material and other Clearinghouse documents available, at no-cost, on-line for those with Internet access.

If you know of something we should have in the clearinghouse, let us know.

Overview

In this introductory packet, the range of conduct and behavior problems are described using fact sheets and the classification scheme from the American Pediatric Association.

Differences in intervention needed are discussed with respect to variations in the degree of problem manifested and include exploration of environmental accommodations, behavioral strategies, and medication.

For those readers ready to go beyond this introductory presentation or who are interested in the topics of school violence, crisis response, or ADHD, we also provide a set of references for further study and, as additional resources, agencies and websites are listed that focus on these concerns.

Conduct and Behavior Problems: Interventions and Resources

This introductory packet contains:

I. Classifying Conduct and Behavior Problems: Keeping the Environment in Perspective as a Cause of Commonly Identified Psychosocial Problems

A. Labeling Troubled and Troubling Youth 1
B. Environmental Situations and Potentially Stressful Events 5
C. Fact Sheet: Conduct Disorder Problems in Children and Adolescents 7

II. The Broad Continuum of Conduct and Behavior Problems 10

A. Developmental Variations 11
B. Problems 13
C. Disorders 15

III. A Quick Overview of Some Basic Resources 17

A. A Few References and Other Sources of Information 18
B. Agencies and Online Resources 20
C. Consultation Cadre Contacts 23

IV. Interventions for Conduct and Behavior Problems 27

A. Accomodations to Reduce Conduct and Behavior Problems 28
B. Behavior Management and Self Instruction 33
  1. Positive Behavioral Support 34
  2. School-wide Behavioral Management Systems 36
  3. In the Face of Predictable Crises 39
  4. Managing Violent and Disruptive Students 43
  5. Addressing Student Problem Behavior 50
  6. Behavior Management in Inclusive Classrooms 57
  7. How to Manage Disruptive Behavior in Inclusive Classrooms 62
C. Empirically Supported Treatment 69
D. Medications 74

V. A Few Resource Aids 78

A. An Example of One State's Disciplinary Program 79
B. Fact Sheets 87
  ➤ Anger 88
  ➤ Behavioral Disorders 93
  ➤ Bullying 96
  ➤ Conduct Disorders 109
  ➤ ODD 113
  ➤ Temper Tantrums 114
C. A Few More Resources from our Center 117

VI. Keeping Conduct and Behavior Problems in Broad Perspective 123

I.Classifying Conduct and Behavioral Problems: Keeping the Environment in Perspective as a Cause of Commonly Identified Psychosocial Problems

A. Labeling Troubled and Troubling Youth

B. Common Behavior Responses to Environmental Situations and Potentially Stressful Events

C. Fact Sheet on Conduct Disorders

I. Keeping The Environment in Perspective as a Cause of Commonly Identified Psychosocial Problems.

A large number of students are unhappy and emotionally upset; only a small percent are clinically depressed. A large number of youngsters have trouble behaving in classrooms; only a small percent have attention deficit or a conduct disorder. In some schools, large numbers of students have problems learning; only a few have learning disabilities. Individuals suffering from true internal pathology represent a relatively small segment of the population. A caring society tries to provide the best services for such individuals; doing so includes taking great care not to misdiagnose others whose "symptoms" may be similar, but are caused by factors other than internal pathology. Such misdiagnoses lead to policies and practices that exhaust available resources in ineffective ways. A better understanding of how the environment might cause problems and how focusing on changing the environment might prevent problems is essential.

A. Labeling Troubled and Troubling Youth: The Name Game

She's depressed.

That kid's got an attention deficit hyperactivity disorder.

He's learning disabled.

What's in a name? Strong images are associated with diagnostic labels, and people act upon these images. Sometimes the images are useful generalizations; sometimes they are harmful stereotypes. Sometimes they guide practitioners toward good ways to help; sometimes they contribute to "blaming the victim" -- making young people the focus of intervention rather than pursuing system deficiencies that are causing the problem in the first place. In all cases, diagnostic labels can profoundly shape a person's future.

Youngsters manifesting emotional upset, misbehavior, and learning problems commonly are assigned psychiatric labels that were created to categorize internal disorders. Thus, there is increasing use of terms such as ADHD, depression, and LD. This happens despite the fact that the problems of most youngsters are not rooted in internal pathology. Indeed, many of their troubling symptoms would not have developed if their environmental circumstances had been appropriately different.

Diagnosing Behavioral, Emotional, and Learning Problems

The thinking of those who study behavioral, emotional, and learning problems has long been dominated by models stressing *person* pathology. This is evident in discussions of cause, diagnosis, and intervention strategies. Because so much discussion focuses on person pathology, diagnostic systems have not been developed in ways that adequately account for psychosocial problems.

Many practitioners who use prevailing diagnostic labels understand that most problems in human functioning result from the interplay of person and environment. To counter nature *versus* nurture biases in thinking about problems, it helps to approach all diagnosis guided by a broad perspective of what determines human behavior.

A Broad View of Human Functioning

Before the 1920's, dominant thinking saw human behavior as determined primarily by person variables, especially inborn characteristics. As behaviorism gained in influence, a strong competing view arose. Behavior was seen as shaped by environmental influences, particularly the stimuli and reinforcers one encounters.

Today, human functioning is viewed in *transactional* terms -- as the product of a reciprocal interplay between person and environment (Bandura, 1978). However, prevailing approaches to labeling and addressing human problems still create the impression that problems are determined by *either* person or environment variables. This is both unfortunate and unnecessary -- unfortunate because such a view limits progress with respect to research and practice, unnecessary because a transactional view encompasses the position that problems may be caused by person, environment, or both. This broad paradigm encourages a comprehensive perspective of cause and correction.

Toward a Broad Framework

A broad framework offers a useful *starting* place for classifying behavioral, emotional, and learning problems in ways that avoid over-diagnosing internal pathology. Such problems can be differentiated along a continuum that separates those caused by internal factors, environmental variables, or a combination of both.

Problems caused by the environment are placed at one end of the continuum (referred to as Type I problems). At the other end are problems caused primarily by pathology within the person (Type III problems). In the middle are problems stemming from a relatively equal contribution of environmental and person sources (Type II problems).

Diagnostic labels meant to identify *extremely* dysfunctional problems *caused by pathological conditions within a person* are reserved for individuals who fit the Type III category.

At the other end of the continuum are individuals with problems arising from factors outside the person (i.e., Type I problems). Many people grow up in impoverished and hostile environmental circumstances. Such conditions should be considered first in hypothesizing what *initially* caused the individual's behavioral, emotional, and learning problems. (After environmental causes are ruled out, hypotheses about internal pathology become more viable.)

To provide a reference point in the middle of the continuum, a Type II category is used. This group consists of persons who do not function well in situations where their individual differences and minor vulnerabilities are poorly accommodated or are responded to hostilely. The problems of an individual in this group are a relatively equal product of person characteristics and failure of the environment to accommodate that individual.

There are, of course, variations along the continuum that do not precisely fit a category. That is, at each point between the extreme ends, environment-person transactions are the cause, but the degree to which each contributes to the problem varies. Toward the environment end of the continuum, environmental factors play a bigger role (represented as E<--->p). Toward the other end, person variables account for more of the problem (thus e<--->P).

Problems Categorized on a Continuum Using a Transactional View of the Primary Locus of Cause

Problems caused by factors in the environment (E)	Problems caused equally by environment and person	Problems caused by factors in the the person (P)

```
     E            (E<--->p)          E<--->P          (e<--->P)            P
|-------------------------------------------|-------------------------------------------|
```

Type I problems	Type II problems	Type III problems
•caused primarily by environments and systems that are deficient and/or hostile	•caused primarily by a significant *mismatch* between individual differences and vulnerabilities and the nature of that person's environment (not by a person's pathology)	•caused primarily by person factors of a pathological nature
•problems are mild to moderately severe and narrow to moderately pervasive	•problems are mild to moderately severe andpervasive	•problems are moderate to profoundly severe and moderate to broadly pervasive

Clearly, a simple continuum cannot do justice to the complexities associated with labeling and differentiating psychopathology and psychosocial problems. However, the above conceptual scheme shows the value of starting with a broad model of cause. In particular, it helps counter the tendency to jump prematurely to the conclusion that a problem is caused by deficiencies or pathology within the individual and thus can help combat the trend toward blaming the victim (Ryan, 1971). It also helps highlight the notion that improving the way the environment accommodates individual differences may be a sufficient intervention strategy.

There is a substantial community-serving component in policies and procedures for classifying and labeling exceptional children and in the various kinds of institutional arrangements made to take care of them. "To take care of them" can and should be read with two meanings: to give children help and to exclude them from the community.

Nicholas Hobbs

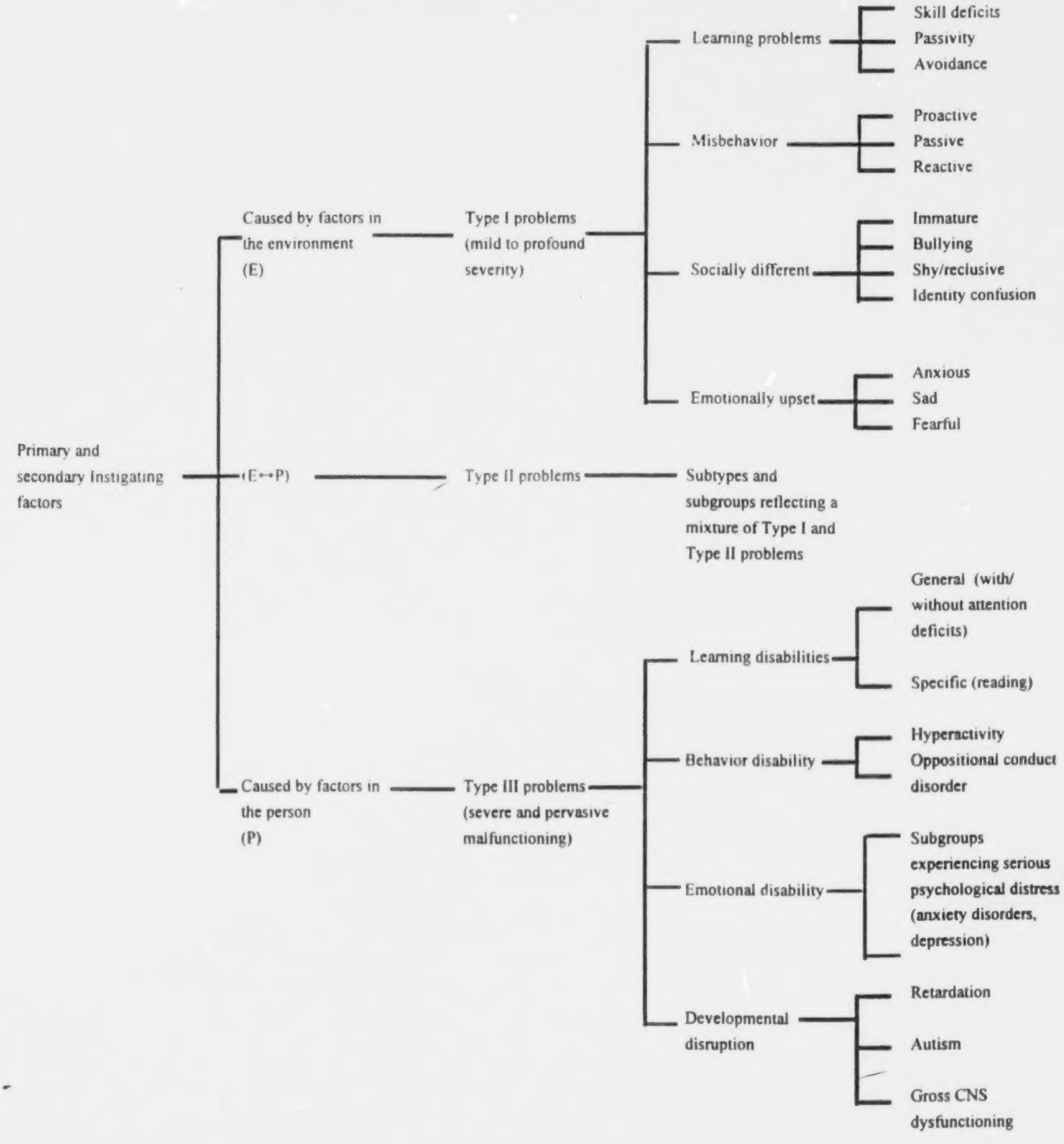
After the general groupings are identified, it becomes relevant to consider the value of differentiating subgroups or subtypes within each major type of problem. For example, subtypes for the Type III category might first differentiate behavioral, emotional, or learning problems arising from serious internal pathology (e.g., structural and functional malfunctioning within the person that causes disorders and disabilities and disrupts development). Then subtypes might be differentiated within each of these categories. For illustrative purposes: Figure 2 presents some ideas for subgrouping Type I and III problems.

References

Bandura, A. (1978). The self system in reciprocal determination. *American Psychologist, 33*, 344-358.

Ryan, W. (1971). *Blaming the victim.* New York: Random House.

Figure 2: Categorization of Type I, II, and III Problems


Primary and secondary Instigating factors
Caused by factors in the environment (E)
Type I problems (mild to profound severity)
Learning problems
Skill deficits
Passivity
Avoidance
Misbehavior
Proactive
Passive
Reactive
Socially different
Immature
Bullying
Shy/reclusive
Identity confusion
Emotionally upset
Anxious
Sad
Fearful
(E↔P)
Type II problems
Subtypes and subgroups reflecting a mixture of Type I and Type II problems
Caused by factors in the person (P)
Type III problems (severe and pervasive malfunctioning)
Learning disabilities
General (with/ without attention deficits)
Specific (reading)
Behavior disability
Hyperactivity
Oppositional conduct disorder
Emotional disability
Subgroups experiencing serious psychological distress (anxiety disorders, depression)
Developmental disruption
Retardation
Autism
Gross CNS dysfunctioning

Source: H. S. Adelman and L. Taylor (1993). Learning problems and learning disabilities. Pacific Grove. Brooks/Cole. Reprinted with permission.

BEST COPY AVAILABLE

B. Environmental Situations and Potentially Stressful Events

The American Academy of Pediatrics has prepared a guide on mental health for primary care providers. The guide suggests that commonly occurring stressful events in a youngsters life can lead to common behavioral responses. Below are portions of Tables that give an overview of such events and responses.

Environmental Situations and Potentially Stressful Events Checklist

- **Challenges to Primary Support Group**
  - Challenges to Attachment Relationship
  - Death of a Parent or Other Family Member
  - Marital Discord
  - Divorce
  - Domestic Violence
  - Other Family Relationship Problems
  - Parent-Child Separation
- **Changes in Caregiving**
  - Foster Care/Adoption/Institutional Care
  - Substance-Abusing Parents
  - Physical Abuse
  - Sexual Abuse
  - Quality of Nurture Problem
  - Neglect
  - Mental Disorder of Parent
  - Physical Illness of Parent
  - Physical Illness of Sibling
  - Mental or Behavioral disorder of Sibling
- **Other Functional Change in Family**
  - Addition of Sibling
  - Change in Parental Caregiver
- **Community of Social Challenges**
  - Acculturation
  - Social Discrimination and/or Family Isolation
- **Educational Challenges**
  - Illiteracy of Parent
  - Inadequate School Facilities
  - Discord with Peers/Teachers
- **Parent or Adolescent Occupational Challenges**
  - Unemployment
  - Loss of Job
  - Adverse Effect of Work Environment
- **Housing Challenges**
  - Homelessness
  - Inadequate Housing
  - Unsafe Neighborhood
  - Dislocation
- **Economic Challenges**
  - Poverty
  - Inadequate Financial Status
- **Legal System or Crime Problems**
- **Other Environmental Situations**
  - Natural Disaster
  - Witness of Violence
- **Health-Related Situations**
  - Chronic Health Conditions
  - Acute Health Conditions

*Adapted from The Classification of Child and Adolescent Mental Diagnoses in Primary Care (1996). American Academy of Pediatrics.

Common Behavioral Responses to -Environmental Situations and Potentially Stressful Events

INFANCY-TODDLERHOOD (0-2Y)

BEHAVIORAL MANIFESTATIONS

- **Illness-Related Behaviors**
  - N/A
- **Emotions and Moods**
  - Change in crying
  - Change in mood
  - Sullen, withdrawn
- **Impulsive/Hyperactive or Inattentive Behaviors**
  - Increased activity
- **Negative/Antisocial Behaviors**
  - Aversive behaviors, i.e., temper tantrum, angry outburst
- **Feeding, Eating, Elimination Behaviors**
  - Change in eating
  - Self-induced vomiting
  - Nonspecific diarrhea, vomiting
- **Somatic and Sleep Behaviors**
  - Change in sleep
- **Developmental Competency**
  - Regression or delay in developmental attainments
  - Inability to engage in or sustain play
- **Sexual Behaviors**
  - Arousal behaviors
- **Relationship Behaviors**
  - Extreme distress with separation
  - Absence of distress with separation
  - Indiscriminate social interactions
  - Excessive clinging
  - Gaze avoidance, hypervigilant gaze...

EARLY CHILDHOOD (3-5Y)

BEHAVIORAL MANIFESTATIONS

- **Illness-Related Behaviors**
  - N/A
- **Emotions and Moods**
  - Generally sad
  - Self-destructive behaviors
- **Impulsive/Hyperactive or Inattentive Behaviors**
  - Inattention
  - High activity level
- **Negative/Antisocial Behaviors**
  - Tantrums
  - Negativism
  - Aggression
  - Uncontrolled, noncompliant
- **Feeding, Eating, Elimination Behaviors**
  - Change in eating
  - Fecal soiling
  - Bedwetting
- **Somatic and Sleep Behaviors**
  - Change in sleep
- **Developmental Competency**
  - Regression or delay in developmental attainments
- **Sexual Behaviors**
  - Preoccupation with sexual issues
- **Relationship Behaviors**
  - Ambivalence toward independence
  - Socially withdrawn, isolated
  - Excessive clinging
  - Separation fears
  - Fear of being alone

MIDDLE CHILDHOOD (6-12Y)

BEHAVIORAL MANIFESTATIONS

- **Illness-Related Behaviors**
  - Transient physical complaints
- **Emotions and Moods**
  - Sadness
  - Anxiety
  - Changes in mood
  - Preoccupation with stressful situations
  - Self -destructive
  - Fear of specific situations
  - Decreased self-esteem
- **Impulsive/Hyperactive or Inattentive Behaviors**
  - Inattention
  - High activity level
  - Impulsivity
- **Negative/Antisocial Behaviors**
  - Aggression
  - Noncompliant
  - Negativistic
- **Feeding, Eating, Elimination Behaviors**
  - Change in eating
  - Transient enuresis, encopresis
- **Somatic and Sleep Behaviors**
  - Change in sleep
- **Developmental Competency**
  - Decrease in academic performance
- **Sexual Behaviors**
  - Preoccupation with sexual issues
- **Relationship Behaviors**
  - Change in school activities
  - Change in social interaction such as withdrawal
  - Separation fear
  - Fear of being alone
- **Substance Use/Abuse...**

ADOLESCENCE (13-21Y)

BEHAVIORAL MANIFESTATIONS

- **Illness-Related Behaviors**
  - Transient physical complaints
- **Emotions and Moods**
  - Sadness
  - Self-destructive
  - Anxiety
  - Preoccupation with stress
  - Decreased self-esteem
  - Change in mood
- **Impulsive/Hyperactive or Inattentive Behaviors**
  - Inattention
  - Impulsivity
  - High activity level
- **Negative/Antisocial Behaviors**
  - Aggression
  - Antisocial behavior
- **Feeding, Eating, Elimination Behaviors**
  - Change in appetite
  - Inadequate eating habits
- **Somatic and Sleep Behaviors**
  - Inadequate sleeping habits
  - Oversleeping
- **Developmental Competency**
  - Decrease in academic achievement
- **Sexual Behaviors**
  - Preoccupation with sexual issues
- **Relationship Behaviors**
  - Change in school activities
  - School absences
  - Change in social interaction such as withdrawal
- **Substance Use/Abuse...**

* Adapted from The Classification of Child and Adolescent Mental Diagnoses in Primary Care (1996). American Academy of Pediatrics

EST COPY AVAILABLE

C. Fact Sheet

Throughout the packet "fact" sheets related to conduct and behavior problems are included to provide a quick overview.

The one that follows focuses specifically on Conduct Disorders.

ommunities together

FACT SHEET

Conduct Disorder in Children and Adolescents

This is one of a series of fact sheets on the mental, emotional, and behavior disorders that can appear in childhood or adolescence. The Center for Mental Health Services extends appreciation to the National Institute of Mental Health for contributing to the preparation of this fact sheet. Any questions or comments about its contents may be directed to the CMHS National Mental Health Services Knowledge Exchange Network (KEN) — see contact information below.

What Is Conduct Disorder?

Children with conduct disorder repeatedly violate the personal or property rights of others and the basic expectations of society. A diagnosis of conduct disorder is likely if the behavior continues for a period of 6 months or longer. Because of the impact conduct disorder has on the child and his or her family, neighbors, and adjustment at school, conduct disorder is known as a "disruptive behavior disorder."

Another disruptive disorder, called oppositional defiant disorder, often occurs before conduct disorder and may be an early sign of conduct disorder. Oppositional defiant disorder is diagnosed when a child's behavior is hostile and defiant for 6 months or longer. Oppositional defiant disorder can start in the preschool years, whereas conduct disorder generally appears when children are somewhat older. Oppositional defiant disorder is not diagnosed if conduct disorder is present.

What Are the Signs of Conduct Disorder?

Some symptoms of conduct disorder include:

- aggressive behavior that harms or threatens to harm other people or animals;
- destructive behavior that damages or destroys property;
- lying or theft; and
- skipping school or other serious violations of rules.

Children with oppositional defiant disorder or conduct disorder may have other problems as well, including:

- hyperactivity;
- anxiety;
- depression;
- academic difficulties; and
- problems with peer relationships.

How Common is Conduct Disorder?

As many as 1 in 10 children and adolescents may have conduct disorder.* Most children and adolescents with conduct disorder do not have lifelong patterns of conduct problems and antisocial behavior.

In this fact sheet, "Mental Health Problems" for children and adolescents refers to the range of all diagnosable emotional, behavioral, and mental disorders. They include depression, attention-deficit/hyperactivity disorder, and anxiety, conduct, and eating disorders, among others. Mental health problems affect one in every five young people at any given time.

"Serious Emotional Disturbances" for children and adolescents refers to the above disorders when they severely disrupt daily functioning in home, school, or community. Serious emotional disturbances affect 1 in every 20 young people at any given time.

**This estimate provides only a rough gauge of the prevalence rates (number of existing cases in a defined time period) for this disorder. The National Institute of Mental Health is currently engaged in a nationwide study to determine with greater accuracy the prevalence of mental disorders among children and adolescents. This information is needed to increase understanding of mental health problems and to improve the treatments and services that help young people who are affected by these conditions.*

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administration • Center for Mental Health Services
5600 Fishers Lane, Room 13-103 • Rockville, Maryland 20857 • Telephone 301.443.2792

CARING FOR EVERY CHILD'S MENTAL HEALTH: Communities Together Campaign

For information about children's mental health, contact the CMHS Knowledge Exchange Network
PO Box 42490 • Washington, DC 20015 • Toll-free 1800.789.2647 ~~• FAX 302.656.~~4012
FAX 301.984.8796 • TTY 301.443.9006 • CMHS Electronic Bulletin Board 1800.790.264

SAMHSA

BEST COPY AVAILABLE

Who Is at Risk?

Years of research show that the most troubling cases of conduct disorder begin in early childhood, often by the preschool years. In fact, some infants who are especially "fussy" are at risk for developing conduct disorder. Other factors that may make a child more likely to develop conduct disorder include:

- inconsistent rules and harsh discipline;
- lack of supervision or guidance;
- frequent change in caregivers;
- poverty;
- neglect or abuse; and
- a delinquent peer group.

In a "System of Care," local organizations work in teams—with families as critical partners—to provide a full range of services to children and adolescents with serious emotional disturbances. The team strives to meet the unique needs of each young person and his or her family in or near their home. These services should also address and respect the culture and ethnicity of the people they serve. (For more information on systems of care, call 1.800.789.2647.)

What Help Is Available for Families?

Conduct disorder is one of the most difficult behavior disorders of childhood and adolescence to treat successfully. However, young people with conduct disorder often benefit from a range of services, which might include:

- parent training on how to handle their child's or adolescent's behavior;
- family therapy;
- training in problem-solving skills for children or adolescents; and
- community-based services that focus on the young person within the context of family and community influences.

A child or adolescent in need of treatment or services and his or her family may need a plan of care based on the severity and duration of symptoms. Optimally, this plan is developed with the family, service providers, and a service coordinator, who is referred to as a case manager. Whenever possible, the child or adolescent is involved in decisions.

Tying together all the various supports and services in a plan of care for a particular child and family is commonly referred to as a "system of care." A system of care is designed to improve the child's ability to function in all areas of life—at home, at school, and in the community.

What Can Parents Do?

Antisocial behavior in children and adolescents is very hard to change after it has become ingrained. Therefore, the earlier the problem is identified and treated, the better. Some recent studies have focused on promising ways to prevent conduct disorder among children and adolescents who are at risk for developing the disorder. Most children or adolescents with conduct disorder are probably reacting to events and situations in their lives. More research is needed to determine if biology is a factor in conduct disorder.

Parents should:

- Pay careful attention when a child or adolescent shows signs of oppositional defiant disorder or conduct disorder and try to understand the reasons behind it. Then parents can try to improve the situation or their own reactions.
- Talk with a mental health or social service professional, such as a teacher, counselor, psychiatrist, or psychologist specializing in childhood and adolescent disorders (if parents cannot reduce their child's or adolescent's antisocial behavior on their own).
- Get accurate information from libraries, hotlines, or other sources.
- Talk to other families in their community.
- Find family network organizations.

It is important for people who are not satisfied with the mental health care they are receiving to discuss their concerns with the provider, to ask for information, and/or to seek help from other sources.

Important Messages About Children's and Adolescents' Mental Health:

- Every child's mental health is important.
- Many children have mental health problems.
- These problems are real and painful and can be severe.
- Mental health problems can be recognized and treated.
- Caring families and communities working together can help.
- Information is available—for free publications, references, and referrals to local and national resources and organizations—call 1.800.789.2647; TTY 301.443.9006; http://www.mentalhealth.org/

II. The Broad Continuum of Conduct and Behavioral Problems

A. Developmental Variations
B. Problems
C. Disorders

The American Academy of Pediatrics has produced a manual for primary care providers that gives guidelines for psychological behaviors that are within the range expected for the age of the child, problems that may disrupt functioning but are not sufficiently severe to warrant the diagnosis of a mental disorder, and disorders that do meet the criteria outlined in the Diagnostic and Statistical Manual of Mental Disorders (4th ed.) of the American Psychiatric Association (DSM-IV).

Just as the continuum of Type I, II, and III problems presented in Section 1A does, the pediatric manual provides a way to describe problems and plan interventions without prematurely deciding that internal pathology is causing the problems. The manual's descriptions are a useful way to introduce the range of concerns facing parents and school staff.

A. Developmental Variations: Behaviors that are Within the Range of Expected Behaviors for That Age Group*

DEVELOPMENTAL VARIATION

Negative Emotional Behavior Variation

Infants and preschool children typically display negative emotional behaviors when frustrated or irritable. The severity of the behaviors varies depending on temperament . The degree of difficulty produced by these behaviors depends, in part, on the skill and understanding of the caregivers.

COMMON DEVELOPMENTAL PRESENTATIONS

Infancy
The infant typically cries in response to any frustration, such as hunger or fatigue, or cries for no obvious reason, especially in late afternoon, evening, and nighttime hours.

Early Childhood
The child frequently cries and whines, especially when hungry or tired, is easily frustrated, frequently displays anger by hitting and biting, and has temper tantrums when not given his or her way.

Middle Childhood
The child has temper tantrums, although usually reduced in degree and frequency, and pounds his or her fists or screams when frustrated.

Adolescence
The adolescent may hit objects or slam doors when frustrated and will occasionally curse or scream when angered.

SPECIAL INFORMATION

These negative emotional behaviors are associated with temperamental traits, particularly low adaptability, high intensity, and negative mood (...). These behaviors decrease drastically with development, especially as language develops. These behaviors are also especially responsive to discipline.

Environmental factors, especially depression in the parent (...), are associated with negative emotional behaviors in the child. However, these behaviors are more transient than those seen in adjustment disorder (...).

These behaviors increase in situations of environmental stress such as child neglect or physical/sexual abuse (...), but again the behaviors are more transient than those seen in adjustment disorder (...).

As children grow older, their negative emotions and behaviors come under their control. However, outbursts of negative emotional behaviors including temper tantrums are common in early adolescence when adolescents experience frustration in the normal developmental process of separating from their nuclear family and also experience a normal increase in emotional reactiveness. However, a decrease in negative emotional behaviors is associated with normal development in middle to late adolescence.

*Adapted from *The Classification of Child and Adolescent Mental Diagnoses in Primary Care.* (1996) American Academy of Pediatrics

ST COPY AVAILABLE

DEVELOPMENTAL VARIATIONS

Aggressive/Oppositional Variation

Oppositionality

Mild opposition with mild negative impact is a normal developmental variation. Mild opposition may occur several times a day for a short period. Mild negative impact occurs when no one is hurt, no property is damaged, and parents do not significantly alter their plans.

COMMON DEVELOPMENTAL PRESENTATIONS

Infancy
The infant sometimes flails, pushes away, shakes head, gestures refusal, and dawdles. These behaviors may not be considered aggressive intentions, but the only way the infant can show frustration or a need for control in response to stress, e.g., separation from parents, intrusive interactions (physical or sexual), overstimulation, loss of family member, change in caregivers.

Early Childhood
The child's negative behavior includes saying 'now as well as all of the above behaviors but with increased sophistication and purposefulness. The child engages in brief arguments, uses bad language, purposely does the opposite of what is asked, and procrastinates.

Middle Childhood
The child's oppositional behaviors include all of the above behaviors, elaborately defying doing chores, making up excuses, using bad language, displaying negative attitudes, and using gestures that indicate refusal.

Adolescence
The adolescent's oppositional behaviors include engaging in more abstract verbal arguments, demanding reasons for requests, and often giving excuses.

SPECIAL INFORMATION

Oppositional behavior occurs in common situations such as getting dressed, picking up toys, during meals, or at bedtime. In early child-hood, these situations broaden to include preschool and home life. In middle childhood, an increase in school-related situations occurs. In adolescence, independence-related issues become important.

DEVELOPMENTAL VARIATIONS

Aggressive/Oppositional Variation

Aggression

In order to assert a growing sense of self nearly all children display some amount of aggression, particularly during periods of rapid developmental transition. Aggression tends to decline normatively with development. Aggression is more common in younger children, who lack self-regulatory skills, than in older children, who internalize familial and societal standards and learn to use verbal mediation to delay gratification.,Children may shift normatively to verbal opposition with development. Mild aggression may occur several times per week, with minimal negative impact.

COMMON DEVELOPMENTAL PRESENTATIONS

Infancy
The infant's aggressive behaviors include crying, refusing to be nurtured, kicking, and biting, but are usually not persistent.

Early Childhood
The child's aggressive behaviors include some grabbing toys, hating siblings and others, kicking, and being verbally abusive to others, but usually responds to parental reprimand.

Middle Childhood
The child's aggressive behaviors include some engaging in all of the above behaviors, with more purposefulness, getting even for perceived injustice, inflicting pain on others, using profane language, and bullying and hitting peers. The behaviors are intermittent and there is usually provocation.

Adolescence
The adolescent exhibits overt physical aggression less frequently, curses, mouths off, and argues, usually with provocation.

SPECIAL INFORMATION

In middle childhood, more aggression and self-defense occur at school and with peers. During adolescence, aggressive and oppositional behaviors blend together in many cases.

*Adapted from The Classification of Child and Adolescent Mental Diagnoses in Primary Care. (1996) American Academy of Pediatrics

EST COPY AVAILABLE

B. Problems--Behaviors Serious Enough to Disrupt Functioning with Peers, at School, at Home, but Not Severe Enough to Meet Criteria of a Mental Disorder. *

PROBLEM

Negative Emotional Behavior Problem

Negative emotional behaviors that increase (rather than decrease) in intensity, despite appropriate caregiver management, and that begin to interfere with child-adult or peer interactions may be a problem. These behaviors also constitute a problem when combined with other behaviors such as hyperactivity/impulsivity (see Hyperactive/ Impulsive Behaviors cluster ...), aggression (see Aggressive/ Oppositional Behavior cluster, ...), and/or depression (see Sadness and Related Symptoms cluster, ...). However, the severity and frequency of these behaviors do not meet the criteria for disorder.

COMMON DEVELOPMENT PRESENTATIONS

Infancy
The infant flails; pushes away, shakes head, gestures refusal, and dawdles. These actions should not be considered aggressive intentions, but the only way the infant can show frustration or a need for control in response to stress--e.g., separation from parents, intrusive interactions (physical or sexual), overstimulation, loss of a family member, or change in caregivers.

Early Childhood
The child repeatedly, despite appropriate limit setting and proper discipline, has intermittent temper tantrums. These behaviors result in caregiver frustration and can affect interactions with peers.

Middle Childhood
The child has frequent and/or intense responses to frustrations, such as losing in games or not getting his or her way. Negative behaviors begin to affect interaction with peers.

Adolescence
The adolescent has frequent and/or intense reactions to being denied requests and may respond inappropriately to the normal teasing behavior of others. The adolescent is easily frustrated, and the behaviors associated with the frustration interfere with friendships or the completion of age-appropriate tasks.

SPECIAL INFORMATION

Intense crying frustrates caregivers. The typical response of caregivers must be assessed in order to evaluate the degree of the problem.

The presence of skill deficits as a source of frustration must be considered (e.g., the clumsy child who does not succeed in games in games in early childhood or in sports in later childhood and adolescence, or the child with a learning disability (...).

---

*Adapted from *The Classification of Child and Adolescent Mental Diagnoses in Primary Care* (1996). American Academy of Pediatrics.

PROBLEM

Aggressive/Oppositional Problem

Oppositionality

The child will display some of the symptoms listed for oppositional defiant disorder (...). The frequency of the opposition occurs enough to be bothersome to parents or supervising adults, but not often enough to be considered a disorder.

COMMON DEVELOPMENT PRESENTATIONS

Infancy
The infant screams a lot, runs away from parents a lot, and ignores requests.

Early Childhood
The child ignores requests frequently enough to be a problem, dawdles frequently enough to be a problem, argues back while doing chores, throws tantrums when asked to do some things, messes up the house on purpose, has a negative attitude many days, and runs away from parents on several occasions.

Middle Childhood
The child intermittently tries to annoy others such as turning up the radio on purpose, making up excuses, begins to ask for reasons why when given commands, and argues for longer times. These behaviors occur frequently enough to be bothersome to the family.

Adolescence
The adolescent argues back often, frequently has a negative attitude, sometimes makes obscene gestures, and argues and procrastinates in more intense and sophisticated ways.

SPECIAL INFORMATION

All children occasionally defy adult requests for compliance, particularly the requests of their parents. More opposition is directed toward mothers than fathers. Boys display opposition more often than girls and their opposition tends to be expressed by behaviors that are more motor oriented. The most intense opposition occurs at the apex of puberty for boys and the onset of menarche for girls.

PROBLEM

Aggressive/Oppositional Problem

Aggression

When levels of aggression and hostility interfere with family routines, begin to engender negative responses from peers or teachers, and/or cause disruption at school, problematic status is evident. The negative impact is moderate. People change routines; property begins to be more seriously damaged. The child will display some of the symptoms listed for conduct disorder (...) but not enough to warrant the diagnosis of the disorder. However, the behaviors are not sufficiently intense to qualify for a behavioral disorder.

*Adapted from *The Classification of Child and Adolescent Mental Diagnoses in Primary Care.* (1996) American Academy of Pediatrics

COMMON DEVELOPMENT PRESENTATIONS

Infancy
The infant bites, kicks, cries, and pulls hair fairly frequently.

Early Childhood
The child frequently grabs others' toys, shouts, hits or punches siblings and others, and is verbally abusive.

Middle Childhood
The child gets into fights intermittently in school or in the neighborhood, swears or uses bad language sometimes in inappropriate settings, hits or otherwise hurts self when angry or frustrated.

Adolescence
The adolescent intermittently hits others, uses bad language, is verbally abusive, may display some inappropriate suggestive sexual behaviors.

SPECIAL INFORMATION

Problem levels of aggressive behavior may run in families. When marked aggression is present, the assessor must examine the family system, the types of behaviors modeled, and the possibility of abusive interactions.

EST COPY AVAILABLE

C. Disorders that Meet the Criteria of a Mental Disorder as Defined by the Diagnostic and Statistical Manual of the American Psychiatric Association (Edition 4, 1994)

DISORDERS

Conduct Disorder Childhood Onset

Conduct Disorder Adolescent Onset

A repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated. Onset may occur as early as age 5 to 6 years, but is usually in late childhood or early adolescence. The behaviors harm others and break societal rules including stealing, fighting, destroying property, lying, truancy, and running away from home.

(see DSM-IV criteria ...)

Adjustment Disorder With Disturbance of Conduct

(see DSM-IV criteria ...)

Disruptive Behavior Disorder, NOS

(see DSM-I V criteria ...)

COMMON DEVELOPMENT PRESENTATIONS

Infancy
It is not possible to make the diagnosis.

Early Childhood
Symptoms are rarely of such a quality or intensity to be able to diagnose the disorder.

Middle Childhood
The child often may exhibit some of the following behaviors: lies, steals, fights with peers with and without weapons, is cruel to people or animals, may display some inappropriate sexual activity, bullies, engages in destructive acts, violates rules, acts deceitful, is truant from school, and has academic difficulties.

Adolescence
The adolescent displays delinquent, aggressive behavior, harms people and property more often than in middle childhood, exhibits deviant sexual behavior, uses illegal drugs, is suspended/expelled from school, has difficulties with the law, acts reckless, runs away from home, is destructive, violates rules, has problems adjusting at work, and has academic difficulties.

SPECIAL INFORMATION

The best predictor of aggression that will reach the level of a disorder is a diversity of antisocial behaviors exhibited at an early age; clinicians should be alert to this factor. Oppositional defiant disorder usually becomes evident before age 8 years and usually not later than early adolescence. Oppositional defiant disorder is more prevalent in males than in females before puberty, but rates are probably equal after puberty. The occurrence of the following negative environmental factors may increase the likelihood, severity, and negative prognosis of conduct disorder: parental rejection and neglect (...), inconsistent management with harsh discipline, physical or sexual child abuse (...), lack of supervision, early institutional living (...), frequent changes of caregivers (...), and association with delinquent peer group. Suicidal ideation, suicide attempts, and completed suicide occur at a higher than expected rate (see Suicidal Thoughts or Behaviors cluster). If the criteria are met for both oppositional defiant disorder and conduct disorder, only code conduct disorder.

---

*Adapted from *The Classification of Child and Adolescent Mental Diagnoses in Primary Care.* (1996) American Academy of Pediatrics

BEST COPY AVAILABLE

DISORDERS

Oppositional Defiant Disorder

Hostile, defiant behavior towards others of at least 6 months duration that is developmentally inappropriate.

- often loses temper
- often argues with adults
- often actively defies or refuses to comply with adults' requests or rules
- often deliberately annoys people
- often blames others for his or her mistakes or misbehavior
- is often touchy or easily annoyed by others
- is open angry and resentful
- is often spiteful or vindictive

(see DSM-IV Criteria...)

COMMON DEVELOPMENT PRESENTATIONS

Infancy
It is not possible to make the diagnosis.

Early Childhood
The child is extremely defiant, refuses to do as asked, mouths off, throws tantrums.

Middle Childhood
The child is very rebellious, refusing to comply with reasonable requests, argues often, and annoys other people on purpose.

Adolescence The adolescent is frequently rebellious, has severe arguments, follows parents around while arguing, is defiant, has negative attitudes, is unwilling to compromise, and may precociously use alcohol, tobacco, or illicit drugs.

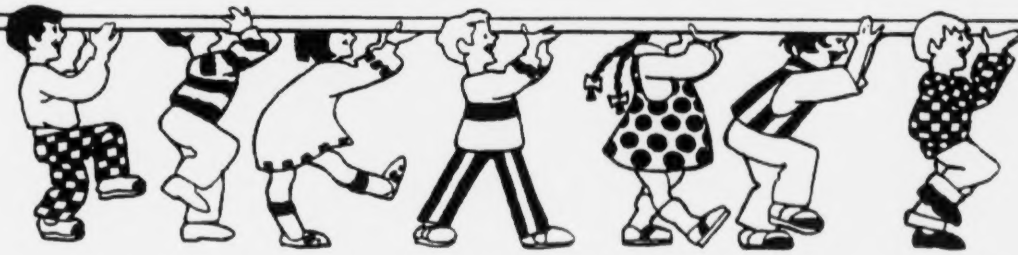
---

*Adapted from *The Classification of Child and Adolescent Mental Diagnoses in Primary Care.* (1996) American Academy of Pediatrics

BEST COPY AVAILABLE

III.

A Quick Overview of Some Basic Resources



A. A Few References and Other Sources of Information

B. Agencies and Online Resources Relevant to Conduct and Behavior Problems

C. Conduct and Behavior Problems: Consultation Cadre Contacts

A. A Few References and Other Sources for Information*

American Psychological Association. (1991). Violence and youth: Psychology's response. Vol. 1: Summary Report of the American Psychological Association Commission on Violence and Youth. Washington, DC: Author.

Behavioral Disorders (1996). *Journal of the Council for Children with Behaioral Disorders.* Special Issue: Research Needs and Issues in Behavioral Disorders. November, Vol. 22, No. 1.

Center for Effective Collaboration and Practice (1998).*Addressing Student Problem Behavior: An IEP Team's introduction to functional behavioral assessment and behavior intervention plans.* Chesapeake Institute: Washington, DC.

Coie, J. D., Dodge, K. A., & Kupersmidt, J. (1990). Peer group behavior and social status. In S.R. Asher & J.D. Coie (Eds.), *Peer rejection in childhood* (pp. 67-99). New York: Cambridge University Press.

Committee for Children. (1992). Second step: A violence prevention curriculum (*Preschool-kindergarten teacher's guide.*) Seattle, WA: Author.

Curwin, R. L. (1995, February). A humane approach to reducing violence in school. *Educational Leadership,52* (5), 72-75.

Dill, V. S. & Haberman, M. (1995, February).Building a gentler school. *Educational Leadership, 52* (5), 69-71.

Dodge, K. A. (1986). A social information processing model of social competence in children. In M. Perlmutter (Ed.), *Cognitivie perspectives on children's social and behavioral development: The Minnesota symposium on child psychology* (Vol. 18, pp 77-126). Hillsdale, NJ: Lawrence Erlbaum Associates.

Dodge, K. A. (1991). The structure and function of reactive and proactive aggression. In D.J. Pepler & K. H. Rubins (Eds.), *Development and treatment of childhood aggression* (pp. 201-218). Hillsdale, NJ:Lawrence erlbaum Associates.

Dodge, K. A., & Coie, J. D. (1987). Social information-processing factors in reactive and proactive aggression in children's peer groups. *Journal of Personality and Social Psychology*, 53, 1146-1158.

Dunlap, Glen & Childs, Karen (1996). Intervention Research in Emotional and Behavioral Disorders: An Analysis of Studies from 1980-1993. *Behavioral Disorders*, February, 21(2), 125-136.

"Emerging School-Based Approaches for Children with Emotional and Behavioral Problems: Research and Practice in Service Integration." (1996). *Special Services in the Schools*, 11.

Feil, Edward, Walker, Hill, & Severson, Herbert (1995). The Early Screening Project for Young Children with Behavior Problems. *Journal of Emotional and Behvioral Disorders*, 3(4), 194-202.

Feindler, E. L., & Eeton, R. B. (1986). Adolescent anger control: *Cognitive-behavioral techniques*. New York: Pergamon Press.

Feindler, E. L., Marriott, S. A., & Iwata, M. (1984). Group anger control training for junior high delinquents. *Cognitive Therapy and Research*, 8, 299-311.

Forness, Steven R.; and Others. (1996). Early Detection and Prevention of Emotional or Behavioral Disorders: Developmental Aspects of Systems of Care. *Behavior Disorders*, May, 21(3), 226-40.

Gamache, D. & Snapp, S. (1995). Teach Your Children Well: Elementary Schools and Violence Prevention. In: *Ending the cycle of violence: Community responses to children of battered women.* Einat Peled, Peter G. Jaffe, Jeffrey L. Edleson, Eds. Sage Publications, Inc, Thousand Oaks, CA, US. 1995. p. 209-231.

Goldstein, A. P., Glick, B., Reiner, S., Zimmerman, D., & Coultry, T. M. (1985). *Aggression replacement training: A comprehensive for aggressive youth.*Champaign, IL: Research Press.

Goldstein, A. P.; Harootunian, B., Conoley, J. C. Student aggression: Prevention, management, and replacement training. Guilford Press; New York, NY, US, 1994.

Hammond, W. R. (1991). *Dealing with anger: A violence prevention program for African-American youth.* Champaign, IL: Research Press.

Hammond, W. R., & Yung, B. R. (1991). Preventing violence in at-risk African-American youth. *Journal of Health Care for the Poor and Underserved*, 2, 358-372.

Hinshaw, S.P. (1994). Conduct disorder in childhood: Conceptualization, diagnosis, comorbidity, and risk factors for antisocial functioning in adulthood. In D.C. Fowles, P. Sutker, & S.H. Goodman (Eds.), *Progress in experimental personality and psychopathology research.* New York: Springer.

Hinshaw, S.P.& Anderson, C.A. (1994). Conduct and oppositional defiant disorders. In E.J. Mash & R.A. Barkley (Eds.), *Child psychopathology*. New York: Guilford.

Illback, Robert J.; Nelson, C. Michael. (1996). School-Based Integrated Service Programs: Toward More Effective Service Delivery for Children and Youth with Emotional and Behavioral Disorders (EBD). *Special Services in the Schools*. 10(2), 1-6.

Johnson, D. & Johnson, R. (1995, February). Why violence prevention programs don't work and what does. *Educational Leadership, 52* (5), 63-67.

Jones, R. N., Sheridan, S. M., & Binns, W. R. (1993). Schoolwide social skills training: Providing preventative services to students at risk. *School Psychology Quarterly*, 8, 58-80.

Jones, Vernon F.. (1996). "In The Face of Predictable Crises": Developing a Comprehensive Treatment Plan for Students with Emotional or Behavioral Disorders. *Teaching Exceptional Children*, 29(2), 54-59.

Kamps, Debra M.; Tankersley, Melody. (1996). Prevention of Behavioral and Conduct Disorders: Trends and Research Issues.*Behavioral Disorders*,22(1), 41-48.

Kazdin, A. E. (1985). *The treatment of antisocial behavior in children and adolescents*. Homewood, IL: Dorsey Press.

Kazdin, A. E (1987). Treatment of antisocial behavior in children: Current status and future directions. *Psychological Bulletin*, 102(2), 187-203.

Larson, J. D. (1990). *Think first: Anger and aggression management for secondary level students* [Video tape].

BEST COPY AVAILABLE

Milwaukee, WI: Milwaukee Board of School Directors.

Larson, J. D. (1992a). Anger and aggression management techniques utilizing the Think First curriculum. *Journal of offender Rehabilitation*, 18, 101-117.

Larson, J. D. (1992b). Think first: Anger and aggression management for secondary level students [Treatment manual]. Whitewater, WI: Author.

Larson, J. D. (in press). Cognitive-behavioral treatment of anger-induced aggression in the school setting. In M. Furlong & D. Smith (Eds.), *Helping all angry, hostile, and aggressive youth: Prevention and assessment strategies*, Brandon, VT: CPPC.

Larson, J. D. & McBride, J. A. (1993). *Parent to parent: A video-augmented training program for the prevention of aggressive behavior in young children*. Milwaukee, WI: Milwaukee Board of School Directors.

Lochman, J. E., Burch, P. R., Curry, J.F., & Lampron, L. B. (1984). Treatment and generalization effects of cognitive behavioral and goal setting intervetions with aggressive boys. *Journal of Consulting and Clinical Psychology*, 52, 915-916.

Lochman, J. E:, Dunn, S. E., & Klimes Dougan, B. (1993). An intervention and consultation model from a social cognitive perspective: A description of the anger coping program. *School Psychology Review, 22*, 458-471.

Lochman, J. E., Lampron, L. B., & Rabiner, D. L. (1989). Format differences and salience effects in assessment of social problem-solving skills of aggressive and nonaggressive boys. *Journal of Clinical Child Psychology*, 18, 230-236.

Lochman, J. E., White, K. J., & Wayland, K. K. (1991). Cognitive-behavioral assessment and treatment with aggressive children. In P.C. Kendall (Ed.), *Child and adolescent therapy: Cognivie-behavioral procedures*. New York: Guilford Press.

McIntyre, Thomas. (1996). Guidelines for Providing Appropriate Services to Culturally Diverse Students with Emotional and/or Behavioral Disorders. *Behavioral Disorders*, 21(2), 137-144.

National Information Center for Children and Youth with Disabilities (April 1997). *Positive behavioral support: A bibliography for schools*. Washington, DC: author. available by calling 1-800-695-0285. or www.nichcy.org

National School Safety Center (1990). *School Safety Check Book*. Malibu, CA: Pepperdine University.

Noguera, P. A. (1995). Preventing and producing violence: A critical analysis of responses to school violence. Special Issue: Violence and youth. *Harvard Educational Review, Summer, 65* (2):189-212.

Northrop, D., Jacklin, B., Cohen, S., & Wilson Brewer, R. (1990). *Violence prevention strategies targeted towards high-risk minority youth*. Background paper prepared for the Forum on Youth Violence in Minority Communities: setting the Agenda for Prevention, Atlanta, GA.

Parks, A.L. (1996). Managing Violent and Disruptive Students. *Crisis Intervention Strategies for School-Based Helpers*, Ch. 8. Springfield, Ill. CC. Thomas.

Patterson, G. R. (1974). Interventions for boys with conduct problems: Multiple settings, treatments, and criteria. Journal of *Consulting and Clinical Psychology*, 42, 471-481.

Patterson, G. R., DeBarsyshe, D. B., & Ramsey, E. (1989). A developmental perspective on antisocial behavior. *Amercan Psychologist*, 44 (2), 329-335.

Patterson, G. R., Reid, J. B., Jones, R. R., & Conger, R. E. (1975). *A social learning approach: Vol. 1. Families with aggressive children*. Eugene, OR: Castilia.

Pettit, G. S., Dodge, K. A., & Brown, M. M. (1988). Early family expereince, social problem solving patterns, and children's social competence. *Child Development*, 59, 107-120.

Prothrow-Stith, D. (1987a). *Violence prevention curriculum for adolescents*. Newton, MA: Education Development Center, Inc.

Prothrow-Stith, D. (1987b). Adolescent violence. The public health approach. *Proceedings of the International Invitational Conference on Channeling Children's Anger* (pp. 95-101). Washingtom, DC.

Prothrow-Stith, D. (1991). *Deadly Consequences*. New York, NY: Harper-Collins.

Radd, Tommie R.; Harsh, Anne Ficenec. (1996). Creating a Healthy Classroom Climate while Facilitating Behavior Change: A Self-Concept Approach. *Elementary School Guidance and Counseling*, 31(2), 153-158.

Research and Training Center on Family Support (1994). *Conduct Disorder*. Research and Training Center on Family Support and Children's Mental Health, Portland State University, P.O. Box 751, Portland, OR 97207-0751; Ph: (503)725-4040

Rockwell, Sylvia; Guetzloe, Eleanor. (1996). Group Development for Students with Emotional/Behavioral Disorders. *Teaching Exceptional Children*, 29(1), 38-43.

Scattergood, P., Dash, K., Epstein, J., & Adler, M. (1998). *Applying Effective Strategies to Prevent or Reduce Substance Abuse, Violence, and Disruptive Behavior among Youth*. Education Development Center, Inc.

Shirner, James G.; Yell, Mitchell L.. (1996). Legal and Policy Developments in the Education of Students with Emotional/Behavior. *Education and Treatment of Children*, 19(3), 371-385.

Stephens, R. D. (1994). Planning for Safer and Better Schools: School Violence Prevention & Intervention Strategies. *School Psychology Review, 23* (2):204-215.

Sudermann, M., Jaffe, P. G., & Hastings, E. (1995). Violence prevention programs in secondary (high) schools. In: *Ending the cycle of violence: Community responses to children of battered women*. Einat Peled, Peter G. Jaffe, Jeffrey L. Edleson (Eds.), Sage Publications, Inc, Thousand Oaks, CA, US. 1995. p. 232-254.

Taylor-Greene, S., Brown, D., Nelson, L., Longton, J., Gassman, T., Cohen, J., Swartz, J., Horner, R., Sugai, G., & Hall, S. (1997). Schoolside behavioral suport: Starting the year off right. *Journal of Behavioral Education*, 7(1), 99-112.

Turnbull, A.P. & Ruef, M. (1997). Family perspectives on inclusive lifestyle issues for nidividuals with problem behavior. *Exceptional Children*, 63(2), 211-227.

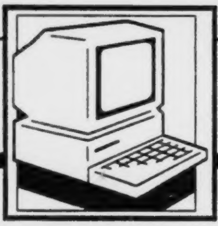
Walker, Hill M.; and Others. (1996). Integrated Approaches to Preventing Antisocial Behavior Patterns among School-Age Children and Youth. *Journal of Emotional and Behavioral Disorders*, 4(4), 194-209.

Webster-Stratton, C. (1989). Systematic comparison of consumer satisfaction of three cost-effective parent training programs for conduct problem children. *Behaivor Therapy*, 20 103-115.

Webster-Stratton, C., Kolpacoff, M., & Hollinsworth, T. (1988). Self-administered videotape therapy for families with conduct-problem children: Comparison with two cost-effective treatments and a control group. *Journal of Consulting and Clinical Psychology*, 56, 458-565.

**** Also see references in previous excerpted articles***

BEST COPY AVAILABLE



B. Agencies and Online Resources Related to Conduct and Behavior Problems

- **Center for the Prevention of School Violence**

  The Center's Safe Schools Pyramid focuses on the problem of school violence. This draws attention to the seriousness of school violence and act as a resource to turn to for information, program assistance, and research about school violence prevention.

  Contact: 20 Enterprise Street, Suite 2, Raleigh, North Carolina 27607-7375
  Phone: 1-800-299-6054 or 919-515-9397 Fax: 919-515-9561
  Website: http://www2.ncsu.edu/ncsu/cep/PreViolence/CtrPreSchVio.html

- **Center for the Study and Prevention of Violence (CSPV)**

  CSPV works from a multi-disciplinary platform on the subject of violence and facilitates the building of bridges between the research community and the practitioners and policy makers. The CSPV Information House has research literature and resources on the causes and prevention of violence and provides direct information services to the public by offering topical searches on customized databases. CSPV also offers technical assistance for evaluation and development of violence prevention programs, and maintains a basic research component on the causes of violence and the effectiveness of prevention and intervention programs.

  Contact: Institute of Behavioral Science, University of Colorado at Boulder
  Campus Box 442. Boulder, CO 80309-0442 Phone: (303) 492-8465
  FAX: (303) 443-3297 E-mail: cspv@colorado.edu Website: http://www.colorado.edu/cspv/

- **Council for Children with Behavioral Disorders**

  CCBD is an international professional organization committed to promoting and facilitating the education and general welfare of children/youth with behavioral and emotional disorders. CCBD, whose members include educators, parents, mental health personnel, and a variety of other professionals, actively pursues quality educational services and program alternatives for persons with behavioral disorders, advocates for the needs of such children and youth, emphasizes research and professional growth as vehicles for better understanding behavioral disorders, and provides professional support for persons who are involved with and serve children and youth with behavioral disorders http://www.air-dc.org/cecp/ccbd/

- **The Council for Exceptional Children (CEC)**

  Is the largest international professional organization dedicated to improving educational outcomes for individuals with exceptionalities, students with disabilities, and/or the gifted. CEC advocates for appropriate governmental policies, sets professional standards, provides continual professional development, advocates for newly and historically underserved individuals with exceptionalities, and helps professionals obtain conditions and resources necessary for effective professional practice. http://www.cec.sped.org/

- **Educational Resources Information Center (ERIC)**

  A national information system designed to provide users with ready access to an extensive body of education-related literature. Educational Resources Information Center Clearinghouse on Counseling and Student Services. http://www.accesseric.org:81/

- **Educational Resources Information Center Clearinghouse on Counseling and Student Services**

  For a list of documents on bullying go to: http://www.uncg.edu/edu/ericcass/bullying/DOCS/tableoc.htm
  (note: some of these documents are included in this packet)

  201 Ferguson Building University of North Carolina at Greensboro,School of Education, Greensboro, NC 27402.
  Ph: (800) 414-9769 (336) 334-4114 FAX:(336) 334-4116

- **Institute on Violence and Destructive Behavior**

  Intention is to empower schools and social service agencies to address violence and destructive behavior, at the point of school entry and beyond, in order to ensure safety and to facilitate the academic achievement and healthy social development of children and youth. Combines community, campus and state efforts to research violence and destructive behavior among children and youth. http://interact.uoregon.edu/ivdb.html

The Joey Support Group Home Page.

This site was created by a parent of a child diagnosed with both ADHD and ODD. She provides support for others who deal with this disorder daily. The Joey Support Group Home Page also provides information on ODD, including signs for parents and teachers to look for, and the interaction between ODD and ADHD. This site also includes links to related sites and where to find treatments and support http://members.aol.com/GramaRO/index.html

Leadership Training for Parents of Oppositional Youth

This website offers information and materials on: Voice Counseling, ODD Rescue Kit, What is ODD? and Should I be concerned?, Is Your Child at Risk? Take This Survey and Find Out, Fast Track quick tips, Treatment and Programs, Alternative Health Treatment Approach. Also see their On-Line Brochure. http://badkids.com/default.htm

National Educational Service

The Bullying Prevention Handbook: A Guide for Teachers, Principals and Counselors
By John Hoover and Ronald Oliver

This handbook provides a comprehensive tool for understanding, preventing, and reducing the day-to-day teasing and harassment referred to as bullying. This collection of effective teaching and counseling models is designed for use by all building-level educators and other professionals involved with disciplinary issues.

1252 Loesch Road * Bloomington, IN 47404-9107 phone (812) 336-7700 * fax (812) 336-7790
email: nes@nesonline.com http://www.kiva.net/~nes/new/bullyingbook.html

National School Safety Center

Created by presidential directive in 1984 to meet the growing need for additional training and preparation in the area of school crime and violence prevention. Affiliated with Pepperdine University, NSSC is a nonprofit organization whose charge is to promote safe schools -- free of crime and violence -- and to help ensure quality education for all America's children.
http://www.nssc1.org

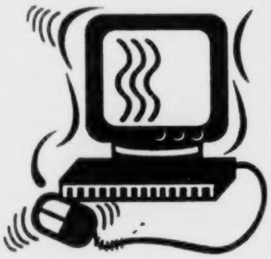
National Youth Gang Center

Purpose is to expand and maintain the body of critical knowledge about youth gangs and effective responses to them. Assists state and local jurisdictions in the collection, analysis, and exchange of information on gang-related demographics, legislation, literature, research, and promising program strategies. Also coordinates activities of the Office of Juvenile Justice & Delinquency Prevention (OJJDP) Youth Gang Consortium -- a group of federal agencies, gang program representatives, and service providers. http://www.iir.com/nygc

Oppositional Defiant Disorder (ODD)http://www.klis.com/chandler/phamphlet/oddcd/about.htm

ODD is a psychiatric disorder that is characterized by two different sets of problems. These are aggressiveness and a tendency to purposefully bother and irritate others. It is often the reason that people seek treatment. When ODD is present with ADHD, depression, tourette's, anxiety disorders, or other neuropsychiatric disorders, it makes life with that child far more difficult. For Example, ADHD plus ODD is much worse than ADHD alone, often enough to make people seek treatment. The criteria for ODD are:
A pattern of negativistic, hostile, and defiant behavior lasting at least six months during which four or more of the following are present:

1. Often loses temper
2. often argues with adults
3. often actively defies or refuses to comply with adults' requests or rules
4. often deliberately annoys people
5. often blames others for his or her mistakes or misbehavior
6. is often touchy or easily annoyed by others
7. is often angry and resentful
8. is often spiteful and vindictive



Oppositional Defiant Disorder

This page contains information and resources on or about Oppositional Defiant Disorder. Its main goal is to give parents and professionals some ideas that may help bring some piece of mind to the child and the family. It includes parenting information and organizational books that help parents learn skills on behavior and anger management http://www.sundial.net/~techman/index3.html

- **Oppositional Defiant Disorder Support Group**
  This site is a companion site to a wonderful message board filled with personal stories. http://www.conductdisorders.com/

- **Partnerships Against Violence Network**
  PAVNET Online is a "virtual library" of information about violence and youth-at-risk, representing data from seven different Federal agencies. It is a "one-stop," searchable, information resource to help reduce redundancy in information management and provide clear and comprehensive access to information for States and local communities. http://www.pavent.org

- **Safe and Drug-Free Schools Programs Office (ED)**
  The Safe and Drug-Free Schools Program is the Federal government's primary vehicle for reducing drug, alcohol and tobacco use, and violence, through education and prevention activities in our nation's schools. The program supports initiatives to meet the seventh National Education Goal, which states that by the year 2000 all schools will be free of drugs and violence and the unauthorized presence of firearms and alcohol, and offer a disciplined environment conducive to learning. These initiatives are designed to prevent violence in and around schools, strengthen programs that prevent illegal use of substances, involve parents, and are coordinated with related Federal, State and community efforts and resources. http://www.ed.gov/offices/OESE/SDFS/

- **Social Development Research Group**
  Research focus on the prevention and treatment of health and behavior problems among young people. Drug abuse, delinquency, risky sexual behavior, violence, and school dropout are among the problems addressed. J. David Hawkins, director, and Richard F. Catalano, associate director, began in 1979 to develop the Social Development Strategy, which provides the theoretical basis for risk- and protective-focused prevention that underlies much of the groups' research. http://weber.u.washington/edu/~sdrg/

- **Tough Love International (TLI)**
  TOUGHLOVE® Parent Support Group is a self-help, active, parent support group for parents troubled by their children's behavior. Many are parents of teen-aged children, but also there are parents of preteens, parents of adult children, and grandparents. There are over 500 parent support groups affiliated with TOUGHLOVE ® International, a nonprofit educational organization. http://www.toughlove.org/

Teaching Children Not To Be -- Or Be Victims Of -- Bullies
http://www.uncg.edu/edu/ericcass/bullying/DOCS/teach.htm

From the National Association for the Education of Young Children. Copyright © 1997 by National Association for the Education of Young Children. Reproduction of this material is freely granted, provided credit is given to the National Association for the Education of Young Children.

Parents and teachers are sometimes reluctant to intervene in conflicts between young children. They don't want to see children harm or ridicule one another, but they want to encourage children to learn how to work out problems for themselves. In such cases, adults have a responsibility to stop violence or aggression in the classroom or at home – both for children who demonstrate harmful behavior and for all other children. We can teach children not to take part in – or become victims of – bullying.

Children who demonstrate aggression, or "bully" other children may be unable to initiate friendly interactions, express their feelings, or ask for what they need. If these children do not improve their social skills, they will continue to have problems relating to peers throughout their lives. In addition, if other children see that aggressors get what they want through bullying, they are more likely to accept or imitate this undesirable behavior.

Young children who are unable to stand up for themselves are easy targets for aggressive playmates. These children inadvertently reward bullies by giving in to them, and risk further victimization. Adults do not help by speaking for victims and solving their problems for them. Children must learn that they have the right to say "No," not only when they are threatened, but in a wide range of everyday situations.

Consultation Cadre

About the Consultation Cadre: Professionals across the country volunteer to network with others to share what they know. Some cadre members run programs; may work directly with youngsters in a variety of settings and focus on a wide range of psychosocial problems. Others are ready to share their expertise on policy, funding, and other major system concerns. The group encompasses professionals working in schools, agencies, community organizations, family resource centers, clinics and health centers, teaching hospitals, universities, and so forth.

People ask how we screen cadre members. We don't! It's not our role to endorse anyone. We think it's wonderful that so many professionals want to help their colleagues, and our role is to facilitate the networking. If you are willing to offer informal consultation at no charge to colleagues trying to improve systems, programs, and services for addressing barriers to learning, let us know. Our list is growing each day; the following are those currently on file related to this topic. Note: the list is alphabetized by Region and State as an aid in finding a nearby resource.

East

District of Columbia

Joan Dodge, Senior Policy Associate
Georgetown University - Child Develop. Center
Nat'l Tech. Assist. Center for Children's MH
3307 M Street, NW
Washington, DC 20007-3935
Ph: (202)687-5000 Fax: (202)687-8899
Email: dodgej@medlib.georgetown.edu

Ronda Talley
425 Eighth Street, NW, #645
Washington, DC 20004
Ph: 202/393-0658 Fax: 202/393-5864

Maine

James Harrod, Res., Planning, & Eval.
Maine Dept. of MH and MR
Bureau of Children with Special Needs
State House
Augusta, ME 04333
Ph: 207/287-4250 Fax: 207/287-4268

Michel Lahti, Project Coordinator
School-Linked Mental Health Services Project
Center for Public Sector Innovation -
U of southern Maine
295 Water Street
Augusta, ME 04333
Ph: 207/626-5274 Fax: 207/626-5210
Email: michel.lahti@state.me.us

Maryland

Lawrence Dolan, Principal Research Scientist
Ctr. for Res. on the Educ. of Students
Placed at Risk, Johns Hopkins University
3505 N. Charles Street
Baltimore, MD 21218
Phone: 410/516-8809 Fax: 410/516-8890
Email: larryd@jhunix.hcf.jhu.edu

William Strein, Associate Professor
University of Maryland
3212 Benjamin Building
1125 College Park
College Park, MD 20742
Phone: 301/405-2869 Fax: 301/405-9995

Massachusetts
Deborah Jencunas, Coordinator
Student Support Services
Boston Public Schools
515 Hyde Park Ave.
Roslindale, MA 02131
Ph: 617/635-8030 Fax: 617/635-8027

New York
Dirk Hightower, Director
Primary Mental Health Project
Univ. of Rochester
575 Mt. Hope Ave.
Rochester, NY 14620
Phone: 716/273-5757 Fax: 716/232-6350
Email: dirk@psych.rochester.edu

Deborah Johnson
Director of Community Services
Primary Mental Health Project
685 South Avenue
Rochester, NY 14620
Phone: 716/262-2920 Fax: 716/262-4761
Email: djohnson@psych.rochester.edu

Pennsylvania
Steven Pfeiffer, Director
Behavioral Health Services
Genesis Health Ventures
Div. of Managed Care
312 W. State St.
Kennett Square, PA 19348
Ph: 610/444-1520

Vermont
Brenda Bean
Program Development Specialist
Dept. of Developmental and MH Services
103 South Main Street
Waterbury, VT 05671
Phone: 802/241-2630 Fax: 802/241-3052
Email: brendab@dmh.state.vt.us

Central States

Iowa
Kathryn Feilneyer
At-Risk Coordinator
Adair-Casey H.S.
3384 Indigo Ave.
Adair, IA 50002
Ph: 515/746-2241 Fax: 515/746-2243

Phillip Mann, Director
Seashore Psychology Clinic
Department of Psychology, E11SH,
University of Iowa
Iowa City, IA 52242
Phone: 319/335-2468 Fax: 319/335-0191
Email: philip-mann@uiowa.edu

Ray Morley
Educ. Services for Children, Family, & Comm.
Iowa Dept. of Education
Grimes State Office Bldg.
Des Moines, IA 50319-0146
Ph: 515/281-3966
Email: rmorley@max.state.ia.us

Kentucky
William Pfohl
Professor of Psychology
Western Kentucky University
Psychology Department
1 Big Red Way
Bowling Green, KY 42101
Phone: 502/745-4419 Fax: 502/745-6474
Email: william.pfohl@wicu.edu

Minnesota
Charlotte Ryan, Consultant for
Youth with Emotional/Behavioral Disorders
Dept. of Children, Families, & Learning
Office of Special Education
550 Cedar St.
ST. Paul, MN 55101
Ph: 612/282-6249 Fax: 612/297-7368

Gordon Wrobel, M.H. Consultant
Minn. Dept. of Children, Families, & Learning
830 Capital Sq. Bldg.
ST. Paul, MN 55101
Ph: 612/297-1641 Fax: 612/297-7368
Email: gordon.wrobel@state.mn.us

Ohio
Joseph E. Zins, Professor
University of Cincinnati
339 Teachers College
Cincinnati, OH 45221-0002
Phone: 513/556-3341 Fax: 513/556-1581
Email: joseph.zins@uc.edu

Wisconsin
Jim Larson, Coordinator
School Psychology Program
University of Wisconsin - Whitewater
Department of Psychology
Whitewater, WI 53190
Phone: 414/472-5412 Fax: 414/472-5716
Email: larsonj@uwwvax.uww.edu

Southeastern States

Arkansas

Maureen Bradshaw
State Coordinator for Behavioral Interventions
Arch Ford Education Service Cooperative
101 Bulldog Drive
Plummerville, AR 72117
Phone: 501/354-2269 Fax: 501/354-0167
Email: mbradshaw@conwaycorp.net

Florida
Howard Knoff, Professor/Director
School Psych. Prog./Institute for School Reform
University of South Florida
4202 East Fowler Avenue, FAO 100U
Tampa, FL 33620-7750
Phone: 813/974-9498 Fax: 813/974-5814
Email: knoff@tempest.coedu.usf.edu

Louisiana .
Dean Frost, Director, Bureau of Student Services
Louisiana State Department of Education
P.O. Box 94064
Baton Rouge, LA 70804
Phone: 504/342-3480 Fax: 504/342-688

North Carolina
Bill Hussey, Section Chief
Dept. of Public Instruction
301 N. Wilmington St.
Raleigh, NC 27601-2825
Phone: 919/715-1576 Fax: 919/715-1569
Email: bhussy@dpi.state.nc.us

William Trant, Director Exceptional Programs
New Hanover County Schools
1802 South 15th Street
Wilmington, NC 28401
Phone: 910/254-4445 Fax: 910/254/4446
Email: wtrant@wilmington.net

Virginia
Richard Abidin, Director of Clinical Training
Curry Programs in Clinical and School Psych.
University of Virginia
405 Emmet Street, 147 Ruffner Hall
Charlottesville, VA 22903-2495
Phone: 804/982-2358 Fax: 804/924-1433
Email: rra@virginia.edu

Southwest

California
Jackie Allen, Professor
Allen Consulting Associates
705 Montana Vista Ct.
Fremont, CA 94539
Phone: 510/656-6857 Fax: 510/656-6880
Email: jjallens@aol.com

Howard Blonsky
Student & Family Service Team Coordinator
Visitacion Valley Middle School
450 Raymond Street
San Francisco, CA 94134
Phone: 415/469-4590 Fax: 415/469-4703

Nancy Flynn, Dir. of Special Education
Tracy Public Schools
315 E 11th St.
Tracy, CA 95376
Ph: 209/831-5029 Fax: 209/832-5068

Mike Furlong, Associate Professor
Graduate School of Education
1324 Phelps Hall
University of California, Santa Barbara
Santa Barbara, CA 93106-9490
Ph: 805/893-3338 Fax: 805/893-7521
Email: mfurlong@education.ucsb.edu

Marcel Soriano
Associate Professor
Division of Administration & Counseling
California State University, Los Angeles
5151 State University Drive
Los Angeles, CA 90032-8141
Phone: 213/343-4381 Fax: 213/343-4252
Email: msorian@calstatela.edu

Andrea Zetlin
Professor of Education
California State University, Los Angeles
School of Education
5151 State University Drive
Los Angeles, CA 90032
Phone: 310/459-2894 Fax: 310/459-2894
Email: azetlin@calstatela.edu

Colorado
Elizabeth Doll, Assoc. Professor
School of Education
University of Colorado at Denver
Campus Box 106, P.O. Box 173364
Denver, CO 80217-3364
Ph: 303/556-8448 Fax: 303/556-4479
Email: beth_doll@together.cudenver.edu

Colorado (cont.)

Kathie Jackson
Program Director, Safe and Drug Free
Colorado Department of Education
201 East Colfax
Denver, CO 80203
Phone: 303/866-6869 Fax: 303/866-6785
Email: jackson_k@cde.state.co.us

Anastasia Kalamaros
Assistant Research Professor
School of Education
University of Colorado at Denver
P.O. Box 173364, Campus Box 106
Denver, CO 80217
Phone: 303/556-3359 Fax: 303/556-4479
Email: stacy_kalamaros@together.cudenver.edu

Hawaii

Don Leton, Psychologist
Honolulu Schools, Special Services
4967 Kilauea Ave.
Honolulu, HI 96816
Ph: 808/733-4940 Fax: 808/733-4944
Email: leton@hula.net

Northwest

Alaska

Coney Danitz, School Counseling Specialist
Dept. of Education
801 W. 10th St., Suite 200
Juneau, AK 99801
Ph: 907/465-8681 Fax: 907/465-2713
Email: coney@innocent.com

Oregon

Philip Bowser, School Psychologist
Roseburg School District
1419 Valley View Drive, NW
Roseburg, OR 97470
Phone: 503/440-4038 Fax: 503/440-4003
Email: pbowser@ednet1.osl.or.gov

Washington

Albert Smith, Director
Center for Study and Teaching of At Risk Students
Univ. of Washington
4725 30th Ave., NE GG12
Seatlle, WA 98105-4021
Ph: 206/543-3815 Fax: 206/685-4722
Email: alsmith@u.washington.edu

In addition,
don't forget to check with

**our Sister Center,
the Center for School Mental
Health Assistance (CSMHA) at
University of Maryland at
Baltimore.**

Contact:

Mark Weist, Ph.D. (Director)
Olga Acosta, Ph.D. (Coordinator)
Dept. of Psychiatry
University of Maryland, Baltimore
680 W. Lexington St., 10th floor
Baltimore, MD 21201-1570
(888)706-0980 / fax: (410)706-0984

IV. INTERVENTIONS FOR CONDUCT AND BEHAVIOR PROBLEMS

A. Accommodations to Reduce Conduct and Behavior Problems

B. Behavior Management and Self Instruction

C. Empirically Supported Treatment

D. Medications

A. Accommodations to Reduce Conduct and Behavior Problems

From the newsletter of the *Center for Mental Health in Schools* of UCLA

Behavior Problems: What's a School to Do?

In their effort to deal with deviant and devious behavior and create safe environments, schools increasingly have adopted social control practices. These include some *discipline* and *classroom management* practices that analysts see as "blaming the victim" and modeling behavior that fosters rather than counters development of negative values.

To move schools beyond overreliance on punishment and social control strategies, there is ongoing advocacy for social skills *training* and new agendas for *emotional "intelligence" training* and *character education*. Relatedly, there are calls for greater home involvement, with emphasis on enhanced parent responsibility for their children's behavior and learning. More comprehensively, some reformers want to transform schools through creation of an atmosphere of "caring," "cooperative learning," and a "sense of community." Such advocates usually argue for schools that are holistically-oriented and family-centered. They want curricula to enhance values and character, including responsibility (social and moral), integrity, self-regulation (self-discipline), and a work ethic and also want schools to foster self-esteem, diverse talents, and emotional well-being.

Discipline

Misbehavior disrupts; it may be hurtful; it may disinhibit others. When a student misbehaves, a natural reaction is to want that youngster to experience and other students to see the consequences of misbehaving. One hope is that public awareness of consequences will deter subsequent problems. As a result, the primary intervention focus in schools usually is on *discipline* -- sometimes embedded in the broader concept of *classroom management*. More broadly, however, as outlined on p. 2, interventions for misbehavior can be conceived in terms of:

- efforts to prevent and anticipate misbehavior
- actions to be taken during misbehavior
- steps to be taken afterwards.

From a prevention viewpoint, there is widespread awareness that program improvements can reduce learning and behavior problems significantly. It also is recognized that the application of consequences is an insufficient step in preventing future misbehavior.

For youngsters seen as having emotional and behavioral disorders, disciplinary practices tend to be described as strategies to modify deviant behavior. And, they usually are seen as only one facet of a broad intervention agenda designed to treat the youngster's disorder. It should be noted, however, that for many students diagnosed as having disabilities the school's (and society's) socialization agenda often is in conflict with providing the type of helping interventions such youngsters require. This is seen especially in the controversies over use of corporal punishment, suspension, and exclusion from school. Clearly, such practices, as well as other value-laden interventions, raise a host of political, legal, and ethical concerns.

Unfortunately, too many school personnel see punishment as the only recourse in dealing with a student's misbehavior. They use the most potent negative consequences available to them in a desperate effort to control an individual and make it clear to others that acting in such a fashion is not tolerated. Essentially, short of suspending the individual from school, such punishment takes the form of a decision to do something to the student that he or she does not want done. In addition, a demand for future compliance usually is made, along with threats of harsher punishment if compliance is not forthcoming. And the discipline may be administered in ways that suggest the student is seen as an undesirable person. As students get older, suspension increasingly comes into play. Indeed, suspension remains one of the most common disciplinary responses for the transgressions of secondary students.

BEST COPY AVAILABLE

Intervention Focus in Dealing with Misbehavior

I. Preventing Misbehavior

A. Expand Social Programs
  1. Increase economic opportunity for low income groups
  2. Augment health and safety prevention and maintenance (encompassing parent education and direct child services)
  3. Extend quality day care and early education

B. Improve Schooling
  1. Personalize classroom instruction (e.g., accommodating a wide range of motivational and developmental differences)
  2. Provide status opportunities for nonpopular students (e.g., special roles as assistants and tutors)
  3. Identify and remedy skill deficiencies early

C. Follow-up All Occurrences of Misbehavior to Remedy Causes
  1. Identify underlying motivation for misbehavior
  2. For unintentional misbehavior, strengthen coping skills (e.g., social skills, problem solving strategies)
  3. If misbehavior is intentional but reactive, work to eliminate conditions that produce reactions (e.g., conditions that make the student feel incompetent, controlled, or unrelated to significant others)
  4. For proactive misbehavior, offer appropriate and attractive alternative ways the student can pursue a sense of competence, control, and relatedness
  5. Equip the individual with acceptable steps to take instead of misbehaving (e.g., options to withdraw from a situation or to try relaxation techniques)
  6. Enhance the individual's motivation and skills for overcoming behavior problems (including altering negative attitudes toward school)

II. Anticipating Misbehavior

A. Personalize Classroom Structure for High Risk Students
  1. Identify underlying motivation for misbehavior
  2. Design curricula to consist primarily of activities that are a good match with the identified individual's intrinsic motivation and developmental capability
  3. Provide extra support and direction so the identified individual can cope with difficult situations (including steps that can be taken instead of misbehaving)

B. Develop Consequences for Misbehavior that are Perceived by Students as Logical (i.e., that are perceived by the student as reasonable fair, and nondenigrating reactions which do not reduce one's sense of autonomy)

III. During Misbehavior

A. Try to base response on understanding of underlying motivation (if uncertain, start with assumption the misbehavior is unintentional)

B. Reestablish a calm and safe atmosphere
  1. Use understanding of student's underlying motivation for misbehaving to clarify what occurred (if feasible, involve participants in discussion of events)
  2. Validate each participant's perspective and feelings
  3. Indicate how the matter will be resolved emphasizing use of previously agreed upon logical consequences that have been personalized in keeping with understanding of underlying motivation
  4. If the misbehavior continues, revert to a firm but nonauthoritarian statement indicating it must stop or else the student will have to be suspended
  5. As a last resort use crises back-up resources
    a. If appropriate, ask student's classroom friends to help
    b. Call for help from identified back-up personnel
  6. Throughout the process, keep others calm by dealing with the situation with a calm and protective demeanor

IV. After Misbehavior

A. Implement Discipline -- Logical Consequences/ Punishment
  1. Objectives in using consequences
    a. Deprive student of something s/he wants
    b. Make student experience something s/he doesn't want
  2. Forms of consequences
    a. Removal/deprivation (e.g., loss of privileges, removal from activity)
    b. Reprimands (e.g., public censure)
    c. Reparations (e.g., of damaged or stolen property)
    d. Recantations (e.g., apologies, plans for avoiding future problems)

B. Discuss the Problem with Parents
  1. Explain how they can avoid exacerbating the problem
  2. Mobilize them to work preventively with school

C. Work Toward Prevention of Further Occurrences (see I & II)

As with many emergency procedures, the benefits of using punishment may be offset by many negative consequences. These include increased negative attitudes toward school and school personnel which often lead to behavior problems, anti-social acts, and various mental health problems. Disciplinary procedures also are associated with dropping out of school. It is not surprising, then, that some concerned professionals refer to extreme disciplinary practices as "pushout" strategies.

(Relatedly, a large literature points to the negative impact of various forms of parental discipline on internalization of values and of early harsh discipline on child aggression and formation of a maladaptive social information processing style. And a significant correlation has been found between corporal punishment of adolescents and depression, suicide, alcohol abuse, and wife-beating.)

Logical Consequences

Guidelines for managing misbehavior usually stress that discipline should be reasonable, fair, and nondenigrating. Motivation theory stresses that "positive, best-practice approaches" are disciplinary acts recipients experience as legitimate reactions that neither denigrate one's sense of worth nor reduce one's sense of autonomy. To these ends, discussions of classroom management practices usually emphasize establishing and administering logical consequences. This idea plays out best in situations where there are naturally-occurring consequences (e.g., if you touch a hot stove, you get burned).

In classrooms, there may be little ambiguity about the rules; unfortunately, the same often cannot be said about "logical" penalties. Even when the consequence for a particular rule infraction has been specified ahead of time, its logic may be more in the mind of the teacher than in the eye of the students. In the recipient's view, any act of discipline may be experienced as punitive -- unreasonable, unfair, denigrating, disempowering.

Basically, consequences involve depriving students of things they want and/or making them experience something they don't want. Consequences take the form of (a) removal/deprivation (e.g., loss of privileges, removal from an activity), (b) reprimands (e.g., public censure), (c) reparations (e.g., to compensate for losses caused by misbehavior), and (d) recantations (e.g., apologies, plans for avoiding future problems).

Defining and Categorizing Discipline Practices

Two mandates capture much of current practice:

(a) schools must teach self-discipline to students;
(b) teachers must learn to use disciplinary practices effectively to deal with misbehavior.

Knoff (1987) offers three definitions of discipline as applied in schools: "(a) ... punitive intervention; (b) a means of suppressing or eliminating inappropriate behavior, of teaching or reinforcing appropriate behavior, and of redirecting potentially inappropriate behavior toward acceptable ends; and (c) ..a process of self-control whereby the (potentially) misbehaving student applies techniques that interrupt inappropriate behavior, and that replace it with acceptable behavior". In contrast to the first definition which specifies discipline as punishment, Knoff sees the other two as nonpunitive or as he calls them "positive, best-practices approaches."

Hyman, Flannagan, & Smith (1982) categorize models shaping disciplinary practices into 5 groups:

- psychodynamic-interpersonal models
- behavioral models
- sociological models
- eclectic-ecological models
- human-potential models

Wolfgang & Glickman (1986) group disciplinary practices in terms of a process-oriented framework:

- relationship-listening models (e.g., Gordon's Teacher Effectiveness Training, values clarification approaches, transactional analysis)
- confronting-contracting models (e.g., Dreikurs' approach,, Glasser's Reality Therapy)
- rules/rewards-punishment (e.g., Canter's Assertive Discipline)

Bear (1995) offers 3 categories in terms of the goals of the practice -- with a secondary nod to processes, strategies and techniques used to reach the goals:

- preventive discipline models (e.g., models that stress classroom management, prosocial behavior, moral/character education, social problem solving, peer mediation, affective education and communication models)
- corrective models (e.g., behavior management, Reality Therapy)
- treatment models (e.g., social skills training, aggression replacement training, parent management training, family therapy, behavior therapy).

BEST COPY AVAILABLE

For instance, teachers commonly deal with acting out behavior by removing a student from an activity. To the teacher, this step (often described as "time out") may be a logical way to stop the student from disrupting others by isolating him or her, or the logic may be that the student needs a cooling off period. It may be reasoned that (a) by misbehaving the student has shown s/he does not deserve the privilege of participating (assuming the student likes the activity) and (b) the loss will lead to improved behavior in order to avoid future deprivation.

Most teachers have little difficulty explaining their reasons for using a consequence. However, if the intent really is to have students perceive consequences as logical and nondebilitating, it seems logical to determine whether the recipient sees the discipline as a legitimate response to misbehavior. Moreover, it is well to recognize the difficulty of administering consequences in a way that minimizes the negative impact on a student's perceptions of self. Although the intent is to stress that it is the misbehavior and its impact that are bad, the student can too easily experience the process as a characterization of her or him as a bad person.

Organized sports such as youth basketball and soccer offer a prototype of an established and accepted set of consequences administered with recipient's perceptions given major consideration. In these arenas, the referee is able to use the rules and related criteria to identify inappropriate acts and apply penalties; moreover, s/he is expected to do so with positive concern for maintaining the youngster's dignity and engendering respect for all.

For discipline to be perceived as a logical consequence, steps must be taken to convey that a response is not a personally motivated act of power (e.g., an authoritarian action) and, indeed, is a rational and socially agreed upon reaction. Also, if the intent is a long-term reduction in future misbehavior, it may be necessary to take time to help students learn right from wrong, to respect others rights, and to accept responsibility.

From a motivational perspective, it is essential that logical consequences are based on understanding of a student's perceptions and are used in ways that minimize negative repercussions. To these ends, motivation theorists suggest (a) establishing a publicly accepted set of consequences to increase the likelihood they are experienced as socially just (e.g., reasonable, firm but fair) and (b) administering such consequences in ways that allow students to maintain a sense of integrity, dignity, and autonomy. These ends are best achieved under conditions where students are "empowered" (e.g., are involved in deciding how to make improvements and avoid future misbehavior and have opportunities for positive involvement and reputation building at school).

Social Skills Training

Suppression of undesired acts does not necessarily lead to desired behavior. It is clear that more is needed than classroom management and disciplinary practices. Is the answer social skills training? After all, poor social skills are identified as a symptom (a correlate) and contributing factor in a wide range of educational, psychosocial, and mental health problems.

Programs to improve social skills and interpersonal problem solving are described as having promise both for prevention and correction. However, reviewers tend to be cautiously optimistic because studies to date have found the range of skills acquired are quite limited and generalizability and maintenance of outcomes are poor. This is the case for training of specific skills (e.g., what to say and do in a specific situation), general strategies (e.g., how to generate a wider range of interpersonal problem-solving options), as well as efforts to develop cognitive-affective orientations (e.g., empathy training). Based on a review of social skills training over the past two decades, Mathur and Rutherford (1996) conclude that individual studies show effectiveness, but outcomes continue to lack generalizability and social validity. (While their focus is on social skills training for students with emotional and behavior disorders, their conclusions hold for most populations.)

For a comprehensive bibliography of articles, chapters, books, and programs on social skills and social competence of children and youth, see Quinn, Mathur, and Rutherford, 1996. Also, see Daniel Goleman's (1995) book on *Emotional Intelligence* which is stimulating growing interest in ways to facilitate social and emotional competence.

Addressing Underlying Motivation

Beyond discipline and skills training is a need to address the roots of misbehavior, especially the underlying motivational bases for such behavior. Consider students who spend most of the day trying to avoid all or part of the instructional program. An intrinsic motivational interpretation of the avoidance behavior of many of these youngsters is that it reflects their perception that school is not a place where they experience a sense of competence, autonomy, and or relatedness to others. Over time, these perceptions develop into strong motivational dispositions and related patterns of misbehavior.

Misbehavior can reflect proactive (approach) or reactive (avoidance) motivation. Noncooperative, disruptive, and aggressive behavior patterns that are proactive tend to be rewarding and satisfying to an individual because the behavior itself is exciting or because the behavior leads to desired outcomes (e.g., peer recognition, feelings of competence or autonomy). Intentional negative behavior stemming from such approach motivation can be viewed as *pursuit of deviance*.

Of course, misbehavior in the classroom often also is reactive, stemming from avoidance motivation. This behavior can be viewed as *protective reactions*. Students with learning problems can be seen as motivated to avoid and to protest against being forced into situations in which they cannot cope effectively. For such students, many teaching and therapy situations are perceived in this way. Under such circumstances, individuals can be expected to react by trying to protect themselves from the unpleasant thoughts and feelings that the situations stimulate (e.g., feelings of incompetence, loss of autonomy, negative relationships). In effect, the misbehavior reflects efforts to cope and defend against aversive experiences. The actions may be direct or indirect and include defiance, physical and psychological withdrawal, and diversionary tactics.

Interventions for such problems begin with major program changes. From a motivational perspective, the aims are to (a) prevent and overcome negative attitudes toward school and learning, (b) enhance motivational readiness for learning and overcoming problems, (c) maintain intrinsic motivation throughout learning and problem solving, and (d) nurture the type of continuing motivation that results in students engaging in activities away from school that foster maintenance, generalization, and expansion of learning and problem solving. Failure to attend to motivational concerns in a comprehensive, normative way results in approaching passive and often hostile students with practices that instigate and exacerbate problems. After making broad programmatic changes to the degree feasible, intervention with a misbehaving student involves remedial steps directed at underlying factors. For instance, with intrinsic motivation in mind, the following assessment questions arise:

- Is the misbehavior unintentional or intentional?
- If it is intentional, is it reactive or proactive?
- If the misbehavior is reactive, is it a reaction to threats to self-determination, competence, or relatedness?
- If it is proactive, are there other interests that might successfully compete with satisfaction derived from deviant behavior?

In general, intrinsic motivational theory suggests that corrective interventions for those misbehaving reactively requires steps designed to reduce reactance and enhance positive motivation for participating in an intervention. For youngsters highly motivated to pursue deviance (e.g., those who proactively engage in criminal acts), even more is needed. Intervention might focus on helping these youngsters identify and follow through on a range of valued, socially appropriate alternatives to deviant activity. From the theoretical perspective presented above, such alternatives must be capable of producing greater feelings of self-determination, competence, and relatedness than usually result from the youngster's deviant actions. To these ends, motivational analyses of the problem can point to corrective steps for implementation by teachers, clinicians, parents, or students themselves. (For more on approaching misbehavior from a motivational perspective, see Adelman and Taylor, 1990; 1993; Deci & Ryan, 1985.)

Some Relevant References

Adelman, H.S., & Taylor, L. (1990). Intrinsic motivation and school misbehavior: Some intervention implications. *Journal of Learning Disabilities. 23*, 541-550.

Adelman, H.S. & Taylor, L. (1993). *Learning problems and learning disabilities: Moving forward*. Pacific Grove, CA: Brooks/Cole.

Bear, G.G. (1995). Best practices in school discipline. In A. Thomas & J. Grimes (Eds.), *Best practices in school psychology -- III*. Washington, DC: National Association of School Psychologists.

Bauer, A.M., & Sapona, R.H. (1991). *Managing classrooms to facilitate learning*. Englewood Cliffs, NJ: Prentice-Hall.

Deci, E.L. & Ryan, R.M. (1985). *Intrinsic motivation and self-determination in human behavior*. New York: Plenum Press.

Duncan, B.J. (1997). Character education: Reclaiming the social. *Educational Theory, 47*, 119-126.

Elias, M.J. Gara, M.A., Schuyler, T.F., Branden-Muller, L.R., & Sayette, M.A. (1991). The promotion of social competence: Longitudinal study of a preventive school-based program. *American Journal of Orthopsychiatry, 61*, 409-417.

Forness, S.R. & Kavale, K.A. (1996). Treating social skill deficits in children with learning disabilities: A meta-analysis of the research. *Learning Disability Quarterly, 19*, 2-13.

Goleman, D. (1995). *Emotional Intelligence*. New York: Bantam Books, Inc.

Greenberg, M.T., Kusche, C.A., Cook, E.T., & Quamma, J.P. (1995). Promoting emotional competence in school-aged children: The effects of the PATHS curriculum. *Development and Psychopathology, 7*.

Gresham, F.M. (1995) Best practices in social skills training. In A Thomas & J. Grimes (Eds.), *Best practices in school psychology -- III* (pp.1021-1030). Washington, DC: National Association of School Psychologists.

Hyman, I., Flanagan, D., & Smith, K. (1982). Discipline in the schools. In C.R. Reynolds & T.B. Gutkin (Eds.), *The handbook of school psychology* (pp. 454-480). New York: Wiley.

Knoff, H.M. (1987). School-based interventions for discipline problems. In C.A. Maher & J.E. Zins (Eds.), *Psychoeducational interventions in the schools* (pp. 118-140). New York: Pergamon.

Mathur, S.R., & Rutherford, R.B. (1995). Is social skills training effective for students with emotional or behavioral disorders? Research issues and needs. *Behavioral Disorders 22*, 21-28.

Quinn, M.M., Mathur, S.R., & Rutherford, R.B. (1996). *Social skills and social competence of children and youth: A comprehensive bibliography of articles, chapters, books, and programs*. Tempe, AZ: Arizona State University.

Wolfgang, C.H. & Glickman, C.D. (1986). *Solving discipline problems: Strategies for classroom teachers* (2nd ed.). Boston: Allyn & Bacon.

IV. INTERVENTIONS FOR CONDUCT AND BEHAVIOR PROBLEMS

A. Accommodations to Reduce Conduct and Behavior Problems

B. Behavior Management and Self Instruction

C. Empirically Supported Treatment

D. Medications

B. Behavior Management and Self-Instruction

1. Positive Behavioral Support
2. School-wide Behavioral Management Systems
3. In the Face of Predictable Crises
4. Managing Violent and Disruptive Students
5. Addressing Student Problem Behavior
6. Behavior Management in Inclusive Classrooms
7. How to Manage Disruptive Behavior in Inclusive Classrooms

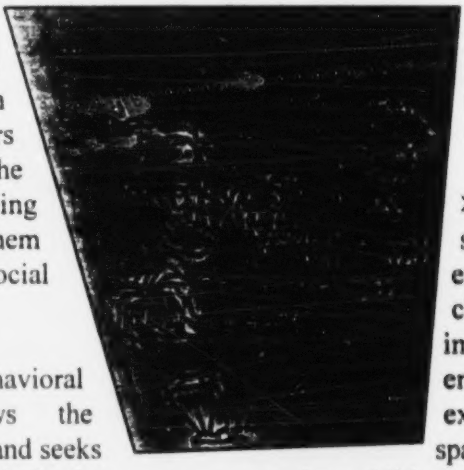
Research Connections
in Special Education
Number 4, Winter 1999

Excerpts From:

Positive Behavioral Support

Helping students with Challenging Behaviors Succeed

Fighting, biting, hitting, scratching, kicking, screaming—as well as extreme withdrawal—are behaviors that challenge even the best educators and families. For years, researchers and practitioners alike have asked the question: Why does a particular child act that way?



Positive behavioral support (PBS) offers one approach for understanding shy the challenging behavior occurs—its function or its purpose for the individual. In addition to helping practitioners and families understand the individual with the challenging behavior, PBS also helps them understand he physical and social contexts of the behavior.

Unlike traditional behavioral management, which views the individual as the sole problem and seeks to "fix" him or her by quickly eliminating the challenging behavior, PBS views such things as settings and lack of skill as parts of the "problem" and works to change those. As such, PBS is characterized as a long-term approach to reducing the inappropriate behavior, teaching a more appropriate behavior, and providing the contextual supports necessary for successful outcomes. .

. . . the following research-based actions to support positive behaviors in individuals with significant disabilities:

➢ ***Respond to individual needs.*** Services and programs should be responsive to the preferences, strengths, and needs of individuals with challenging behavior. In addition, students may benefit from instruction in self-determination skills, social skills, goal-setting, and independent learning skills.

➢ ***Alter environments.*** If some-thing in the individual's environment influences the challenging behavior, it is important to organize the environment for success. For example, clearly defined work spaces and quiet work areas may assist a child who is noise-sensitive.

➢ ***Teach new skills to the individual with challenging behavior and members of his or her social network.*** Individuals need to be taught alternative, appropriate responses that serve the same purpose as the challenging behavior.

➢ ***Appreciate positive behaviors***. It is important to reinforce and acknowledge all positive behaviors consistently. . .

To address the behavioral needs of all students...

➢ ***Schoolwide support*** - procedures and

BEST COPY AVAILABLE

processes that are intended for all students, all staff, and all settings. The most important element of support is a building-wide team that over-sees all development, implementation, modification, and evaluation activities.

➢ ***Specific setting support*** - a team-based mechanism for monitoring specific settings that exist within the school environment. In settings where problem behaviors occur, teams should develop strategies that prevent or minimize their occurrence.

➢ ***Classroom support*** - processes and procedures of the individual classrooms where teachers structure learning opportunities. They should parallel the features and procedures that are used schoolwide.

➢ ***Individual student support*** - immediate, relevant, effective, and efficient responses to students-who present the most significant behavioral challenges; processes and procedures for high-intensity, specially designed and individualized interventions for the estimated 3 to 7 percent of students who present the most challenging behavior.

Strategies for the schoolwide, specific setting, and classroom levels include having:

- ➢ A clear, positive purpose.
- ➢ A set of positively stated expectations for prosocial behavior.
- ➢ Procedures for teaching schoolwide expectations.
- ➢ A continuum of procedures for encouraging students to display expected behaviors.
- ➢ A continuum of procedures for discouraging violations of schoolwide expectations.
- ➢ A method for monitoring implementation and effectiveness.

At the student level, procedures include functional assessment strategies, social skills instruction, self-management training, and direct instruction. For implementation of the procedures at the individual student level to be effective, schoolwide PBS must be in place and functioning efficiently....

➢➢➢➢➢➢➢➢➢➢➢➢➢➢➢➢➢➢➢➢➢➢➢

ERIC/OSEP Special Project
The ERIC Clearinghouse on Disabilities and Gifted Education
The Council for Exceptional Children
1920 Association Dr.
Reston, VA 20191-1589
(703)620-3660 TTY(703)264-9449

School-Wide Behavioral Management Systems

By: Mary K. Fitzsimmons

ERIC Digest

For over a quarter of a century, the number one concern facing America's public schools has been discipline. What educators are finding, however, is that the root of the problem goes beyond rule-breaking. Many of today's students need more than just sound and consistent discipline policies they also need positive behavioral instruction.

Consequently, educators have been seeking new ways to move beyond traditional "punishment" and provide opportunities for all children to learn self-discipline. Simultaneously, researchers have begun to study and advocate for broader, proactive, positive school-wide discipline systems that include behavioral support. One promising avenue for achieving the dual goals of teaching self-discipline and managing behavior is school-wide behavior management.

While there are different variations of school-wide systems of behavioral support, most have certain features in common (see box below). The emphasis is on consistency both throughout the building and across classrooms. The entire school staff (including cafeteria workers and bus drivers) is expected to adopt strategies that will be uniformly implemented. As a result, these approaches necessitate professional development and long-term commitment by the school leadership for this innovation to take hold. A few examples of promising behavioral management systems follow.

☆EFFECTIVE BEHAVIORAL SUPPORT

Effective Behavioral Support (EBS) refers to a system of school-wide processes and individualized instruction designed to prevent and decrease problem behavior and to maintain appropriate behavior. It is not a model with a prescribed set of practices. Rather, it is a team-based process designed to address the unique needs of individual schools. Teams are provided with empirically validated practices and, through the EBS process, arrive at a school-wide plan. Steps in the process include:

1. Clarify the need for effective behavioral support and establish commitment, including administrative support and participation. Priority for this should be reflected in the school improvement plan.

2. Develop a team focus with shared ownership.

3. Select practices that have a sound research base. Create a comprehensive system that prevents as well as responds to problem behavior. Tie effective behavioral support activities to the school mission.

4. Develop an action plan establishing staff responsibilities.

5. Monitor behavioral support activities. Continue successful procedures; change or abandon ineffective procedures.

According to researcher Tim Lewis of the University of Missouri, several factors foster EBS success:

1. Faculty and staff must agree that school-wide behavioral management is one of their top priorities and will probably require 3 to 5 years for completion.

2. Teams must start with a "doable" objective that meets their needs and provides some initial success.

3. Administrators must support the process by respecting team decisions, providing time for teams to meet, securing ongoing staff training, and encouraging all staff to participate.

☆ COMMON FEATURES OF SCHOOL-WIDE BEHAVIORAL MANAGEMENT SYSTEMS

1. Total staff commitment to managing behavior, whatever approach is taken.

2. Clearly defined and communicated expectations and rules. Consequences and clearly stated procedures for correcting rule-breaking behaviors.

3. An instructional component for teaching students self-control and/or social skill strategies.

4. A support plan to address the needs of students with chronic, challenging behaviors.

☆ EXPANDING PLACEMENT OPTIONS

As part of an OSEP research project designed to support systems change strategies for students with emotional and behavioral disabilities, researcher Doug Cheney of the University of Washington and his colleagues are studying school-wide management plans that (a) teach and support prosocial behavior and (b) identify consistent school-wide responses to challenging behaviors.

Initial findings are encouraging: The implementation of school-wide structures appears to add to the presently existing continuum of services, which increases the school's ability to expand placement options for students with severe emotional disturbance.

One school in the process of implementing this model began by developing a unified code of conduct. When a child does not follow the code, teachers use a standard set of school-wide disciplinary procedures. When the behavior escalates above typical, low-level classroom violations, the procedures include a social cognitive problem-solving component.

☆ SCHOOL-WIDE CODE OF CONDUCT

Safety: Are my actions safe for myself and for others?

Respect: Do my actions show respect for myself and for others?

Honesty: Do my words and actions represent truth?

Responsibility: Do my actions meet the expectation to take care of myself and be a dependable member of the community?

Courtesy: Do my actions help make this a nice place, where people feel welcome and accepted, and where they can do their work without disruptions?

Developed by Fuller Elementary School, North Conway NH.

☆ UNIFIED DISCIPLINE

As part of an OSEP-funded primary prevention project, Bob Algozzine and Richard White, at the University of North Carolina-Charlotte, are studying a school-wide approach to behavioral management called Unified Discipline.

Four objectives drive the efforts to implement this system:

Unified attitudes: Teachers and school personnel believe that instruction can improve behavior, behavioral instruction is part of teaching, personalizing misbehavior makes matters worse, and emotional poise underlies discipline methods that work.

Unified expectations: Consistent and fair expectations for behavioral instruction are a key to successful discipline plans.

Unified consequences: Using a warm yet firm voice, teachers state the behavior, the violated rule, and the unified consequence and offer encouragement.

Unified team roles: Clear responsibilities are described for all school personnel.

Preliminary data on Unified Discipline show promising trends such as reductions in office referrals.

☆ IS A SCHOOL-WIDE SYSTEM RIGHT FOR YOU?

Clearly, from a preventive standpoint, researchers would agree that all schools can benefit from having in place a clearly defined, consistently enforced behavioral management system that is designed to support students in controlling their own behaviors.

In cases where school staff have significant concerns about discipline, a school-wide system may be a welcome solution. For a fuller look at the research discussed in this digest, the reader is referred to Research Connections, Fall 1997, published by the ERIC/OSEP Special Project.

☆ REFERENCES

Cheney, D., Barringer, C., Upham, D., & Manning, B.(1995). Project DESTINY: A model for developing educational support teams through interagency networks for youth with emotional or behavioral disorders. Special Services in the Schools, 10(2), 57-76.

Colvin, G., Kameenui, E. J., & Sugai, G. (1993). Reconceptualizing behavior management and school-wide discipline in general education. Education and Treatment of Children, 16(4), 361-381.

Jones, V. (1993). Assessing your classroom and school-wide student management plan. Beyond Behavior, 4(3), 9-12.

Lewis, T. (1997). Responsible decision making about effective behavioral support. Available through the ERIC Clearinghouse.

Pennsylvania Department of Education, Bureau of Special Education. (1995). Guidelines: Effective behavioral support. Harrisburg, PA: Author.

Reavis, H. K., Kukic, S. J., Jenson, W. R., Morgan, D. P., Andrews, D. J., & Fister, S. (1996). BEST Practices. Longmont, CO: Sopris West Publishers.

Sugai, G. & Pruitt, R. (1993). Phases, steps and guidelines for building school-wide behavior management programs: A practitioners handbook. Eugene, OR: Behavior Disorders Program.

Taylor-Green, S., Brown, D., Nelson, L., Longton, J., Cohen, J., Swartz, J., Horner, R., Sugai, G., & Hall, S. (in press). School-wide behavioral support: Starting the year off right. Journal of Behavioral Education.

Thomas, A., & Grimes, J. (1995). Best practices in school psychology - III. Silver Spring, MD: National Association of School Psychologists.

Walker, H., Horner, R., Sugai, G., Bullis, M., Sprague, J., Bricker, D., & Kaufman, M. (1996). Integrated approaches to preventing antisocial behavior patterns among school age children and youth. Journal of Emotional and Behavioral Disorders, 4, 193-256.

ED417515 98 School-Wide Behavioral Management Systems. ERIC/OSEP Digest #E563. Author: Fitzsimmons, Mary K.

ERIC Clearinghouse on Disabilities and Gifted Education, Reston, VA.

THIS DIGEST WAS CREATED BY ERIC, THE EDUCATIONAL RESOURCES INFORMATION CENTER. FOR MORE INFORMATION ABOUT ERIC, CONTACT ACCESS ERIC 1-800-LET-ERIC

This publication was prepared with funding from the Office of Special Education Programs, U.S. Department of Education, under contract no. RR93002005. The opinions expressed in this report do not necessarily reflect the positions or policies of OSEP or the Department of Education.

Excerpt:

"In the Face of Predictable Crises"

Developing a Comprehensive Treatment Plan for Students with Emotional or Behavioral Disorders

Vernon F. Jones

THE COUNCIL FOR EXCEPTIONAL CHILDREN
TEACHING EXCEPTIONAL CHILDREN NOV/DEC 1996 pp 54-59

... *Key Intervention Components*

Behavior change programs for students with serious emotional and behavioral disorders fall into four major categories of interventions:

1. Ecological/environmental.
2. Skill building.
3. Contingency management.
4. Self-esteem/insight-oriented issues.

Wood (1990) suggested a similar categorization when, after discussing behavioral interventions, he stated, "The term *interventions* covers a broad array of approaches which have emerged from developmental and social perspectives, including social skills training, ecological interventions, and affective education" (p. 106). Though these areas are not mutually exclusive, they stem from separate research paradigms and groups of researchers.

Ecological/Environmental Factors

Many researchers have focused on how school and classroom factors influence student learning and behavior. This work has perhaps best been summarized in *Looking in Classrooms (Good* & Brophy, 1994). These researchers have involved special educators and psychologists in assessing the factors most important for facilitating learning.

Ecological changes are almost always necessary. Indeed, if the school environment were effective in eliciting acceptable behavior and learning from a child, it is highly unlikely that a Multidisciplinary Team would determine a child eligible for special services. Walker (1986) has thoughtfully discussed the importance of including the behavior requirements of the mainstream environment when developing a student's behavior change plan. We should also consider modifications that can be made in the environment to respond to the special education student's unique learning and personal needs (Fuchs, Fuchs, Fernstrom, & Hohn, 1991; Good & Brophy, 1994; Hawkins, Doueck, & Lishner, 1988; Jones & Jones, 1995; Maag & Reid, 1994).

Skill Building

Although modified environments can dramatically alter children's behavior, most students with serious emotional and behavioral disorders need to learn specific new skills if they are to function successfully in the mainstream. The second category of strategies, *skill building*, generally includes interventions often termed *cognitive-*

emotional interventions (Anger & Cole, 1991). These include self-instruction, problem-solving, and social skill training.

As Knitzer et al. (1990) indicated, social skill training is included in some EBD programs; but teachers too often fail to design specific practice of these new skills, reinforce students' use of the skills, or help students correct and repractice skills that they fail to use consistently.

Contingency Management

The third category includes contingency management methods. These are described by Nelson and Rutherford (1988) as *behavior enhancement and reduction procedures* and include various types of reinforcement, as well as such methods as extinction, response cost, and timeout.

Many students with serious behavioral disorders will require contingency management intervention designed to maintain their behavior within acceptable limits. This will be necessary both to maintain the student within the school setting and to provide an opportunity for other interventions to be effective.

Limit setting enables students to be reinforced for appropriate behavior and also assists students in benefiting from the cognitive-behavioral interventions designed as part of the student's IEP. Masterson and Costello (1980) noted that behavioral limits prevent students with emotional and behavioral disorders from acting out feelings. This increases the likelihood that the feelings will be expressed, and the student can be assisted in appropriately expressing and understanding the feelings.

Contingency management interventions may take the form of *point and levels systems* used with all students in the program (Smith & Farrell, 1993) or may involve a variety of individualized behavior management approaches, including self-monitoring or individual contracts (Jones & Jones, 1995; Lloyd, Landrum, & Hallahan, 1991; Sprick & Howard, 1995).

Self-Esteem/Insight-Oriented Issues

Finally, many students with serious emotional and behavioral disorders suffer from *serious self-esteem, depression, and anxiety impairment* (Capaldi, 1992; Greenberg, Speltz, & DeKlyen, 1993; Morse, 1985). Their developmental histories have often been characterized by turmoil, uncertainty, abuse, neglect, unclear family communication, abandonment, and ineffective modeling (Dishion, French, & Patterson, 1995; Izard & Harris, 1995). For example, a child who is terrified of an abusive parent and yet afraid of being abandoned by this parent may withdraw into fantasy or strike out against other children or adults who are safer than the parent. A purely behavioral program may focus exclusively on modifying the aggressive or fantasy behavior.

A number of writers have discussed the importance of interventions in the affective domain which help students understand themselves and their environment (Jones, 1992; Masterson & Costello, 1980; Nichols & Shaw, 1995; Nielsen, 1983; Wilkes, Beschler, Rush, & Frank, 1994).

Providing students with an *understanding of their own dysfunctional perceptions and clarifying their own reality* can provide a basis for healthy self-esteem and productive self-talk. My own work with students experiencing serious emotional disorders (Jones, 1992) supports the work cited above in suggesting that treatment programs are most effective when staff point out both the child's overgeneralized comments and clarify the underlying clinical issues associated with the child's emotional disturbance and un-productive behaviors....

References

Anger, C., & Cole, C. (1991). A review of cognitive-behavioral interventions for children and adolescents with behavioral disorders. *Behavioral Disorders*. 16(4), 276-287.

Browning-Wright, D., & Gurman, H. (1994). *Positive intervention for serious behavior* *problems.* Resources in Special Education: 650 Howe Ave., Suite 300, Sacramento, CA 95825. (ERIC Document Reproduction Service No. ED 383 157)

Capaldi, D. (1992). The co-occurrence of conduct problems and depressive symptoms in early adolescent boys: 11. A 2-year follow-up at grade 8. *Development and Psychopathology,* 4, 125-144.

Coopersmith, S. (1967). *The antecedents of self-esteem.* San Francisco: W. H. Freeman.

???lion, T., French, D., & Patterson, G. (1995). The development and ecology of antisocial behavior. In D. Cicchetti & D. Cohen (Eds.) *Developmental Psychopathology, Volume 2.* New York: John Wiley.

Dunlap, G., Kern, L., dePerczel, M., Clarke, S., Wilson, D., Childs, K., White, R., & Falk, G. (1993). Functional analysis of classroom variables for students with emotional and behavioral disorders. *Behavioral Disorders,* 18(4), *275-291.*

Fuchs, D., Fuchs., L. Fernstrom, R. & Hohn, M. (1991). Toward a responsible integration of behaviorally disordered students. *Behavioral disorders,* 16, 133-147.

Good, T., & Brophy, J. (1994). *Looking in classrooms* (6th ed.). New York: Harper Collins.

Greenberg, M., Speltz, M., & DeKlyen, M. (1993). The role of attachment in early development of disruptive behavior problems. *Development and Psychopathology,* 5, 191-213.

Haring, N., Jewell, J., Lehning, T., Williams, G., & White, O. (1987). Research on severe behavior disorders: A study of statewide identification and service delivery to children and youth. In N. Haring (Ed.), A*ssessing and managing behavior disabilities,* 39-104. Seattle: University of Washington Press.

Hawkins, D., Doueck, H., & Lishner, D. (1988). Changing teaching practices in mainstream classrooms to improve bonding and behavior of low achievers. American *Educational Research Journal, 25,* 31-50.

Izard, C., & Harris, R (1995). Emotional development and developmental psychopathology. In D. Cicchetti & D. Cohen (Eds.), Developmental Psychopathology, *Volume 1* (467-503). New York: John Wiley.

Jones, V. (1980). *Adolescents* with *behavior problems: Strategies for teaching counseling and parent involvement.* Boston: Allyn & Bacon .

Jones, V. (1987). Major components in a comprehensive program for seriously emotionally disturbed children. In R. Rutherford, C. Nelson, & S. Forness (Eds.), *Severe behavior disorders of children and youth* (Vol. 10) . Boston: College Hill.

Jones, V. (1992). Integrating behavioral and insight-oriented treatment in school based programs for seriously emotionally disturbed students. *Behavioral Disorders,*] *7,* 225-236.

Jones, V, & Jones, L. (1995). *Comprehensive classroom management: Motivating and managing students at risk (4th ed.).* Boston: Allyn & Bacon.

Kauffman, J., Lloyd, J., Cook, L., Cullinan, D., Epstein, M., Forness, S., Hallahan, D., Nelson, M., *Polsgrove,* L., Sabornie, E., Strain, P., & Walker, H. Peacock Hill Working Group. (1990). "Problems and Promises in Special Education and Related Services for Children and Youth with Emotional or Behavioral Disorders": Peacock Hill, Charlottesville, Virginia. A version of this paper was later printed in Behavioral Disorders, 26(4), 299-313.

Knitzer, J., Steinberg, Z., & Fleisch, B. (1990). *At the schoolhouse door: An examination of programs and policies for children with behavioral and emotional problems.* New York: Bank Street College of Education.

Lennox, D., & Miltenberger, R. (1989). Conducting a functional assessment of problem behavior in applied settings. *Journal of the Association of Persons with Severe Handicaps,* 14, 304-311.

Lloyd, J., Kauffman, J., & Kupersmidt, J. (1990). Integration of students with behavior disorders in regular education environments. In D. Gadow (Ed.), *Advances in learning and behavioral disabilities. Vol. 6.* Greenwich, CT: JAI.

Lloyd, J., Landrum, T., & Hallahan, D. (1991).

Self-monitoring applications for classroom interventions. In G. Stoner, M. Shinn, & H. Walker (Eds), *Interventions for achievement and behavior problems (pp.* 201-213). Silver Spring, MD: National Association of School Psychologists. (ERIC Document Reproduction Service No. ED 353 489)

Maag, J., & Reid, R. (1994). Attention-deficit hyperactive disorder: A functional approach to assessment and treatment. *Behavioral disorders,* 20, 5-23.

Masterson, J., & Costello, J. (1980). *From borderline adolescent to functioning adult:* The *test of time.* New York: Brunner/Mazel.

Morse, W. (1985). The *education and treatment of socioemotionally disturbed children and youth.* Syracuse, NY: Syracuse University Press.

Nelson, C., & Rutherford, R. (1988). Behavioral interventions with behaviorally disordered students. In M. Wang, M. Reynolds, & H. Walberg (Eds.), *Handbook of special education: Research and practice. Vol. 2.* New York: Pergamon Press.

Nichols, R. & Shaw, M. (1995). *Clear thinking—clearing dark thought with new words and images: A program for teachers and counseling professionals.* Iowa City, IO: River Lights Publishers.

Nielsen, G. (1983). *borderline and acting out adolescents: A developmental approach.* New York: Human Sciences.

Reynolds, W., & Stark, K. (1987). School-based intervention strategies for the treatment of depression in children and adolescents. In S. Forman (Ed.), *School-based affective and social interventions. New* York: Plenum Press.

Satterfield, J., Satterfield, M., & Cantwell, D. (1981). Three-year multimodality treatment study of 100 hyperactive boys. *The Journal of pediatrics, 4, 650-655.*

Smith, S. (1990). Comparison of individualized education programs (IEPs) of students with behavioral disorders and learning disabilities. *Journal of Special Education, 24,* 85- 100.

Smith, S., & Farrell, D. (1993). Level system use in special education: Classroom intervention with prima facie appeal. *Behavioral disorders,* 18, 251 -264.

Sprick, R., & Howard, L. (1995). *the **teacher's** encyclopedia of behavior management: 100 problems/500 plans.* Longmont, CO: Sopris *West.*

Sugai, G., & Tindal, G. (1993). Effective school consultation: An interactive approach. *Pacific Grove, CA: Brooks/Cole.*

U.S. Department of Education. (1994). *Sixteenth annual report to Congress on the implementation of the Individuals with Disabilities Education Act.* Washington, DC: U.S. Government Printing Office. (ERIC Document Reproduction Service No. ED 373 531)

Walker, H. (1986).The AIMS (Assessment for Integration into Mainstream Settings) assessment system: Rationale, instruments, procedures, and outcomes. *Journal of Clinical Child Psychology,* 15, 55-63.

Wilkes, T., Beschler, G., Rush, A., & Frank. E. *(1994). Cognitive therapy for depressed adolescents.* New York: Guilford Press.

Wood, E (1990). Issues in the education of behaviorally disordered students. In M. Wang, M. Reynolds, & H. Walberg (Eds.), *Special education: Research and practice: Synthesis of findings (pp. 101-118).* New York: Pergamon Press.

Vernon E Jones *(CEC Oregon Federation), Professor, Department of Education, Lewis & Clark Siege, Portland, Oregon.*
Address correspondence to:
Vernon E Jones,
Department of Education,
Lewis & Clark College,
Portland, OR 97219.

Copyright 1996 CEC.

Excerpts from:

MANAGING VIOLENT AND DISRUPTIVE STUDENTS

By: A. LEE PARKS

in: Crisis Intervention Strategies for School-Based Helpers
Edited by Thomas N. Fairchild. Springfield, Ill., U.S.A. : C.C. Thomas, c1986.

➤ INTRODUCTION

...A certain amount of aggression is a sign of a well-balanced personality. Occasionally, normal children are violent and disruptive - hitting others, being verbally abusive, or creating commotions while the teacher is instructing. They are learning how to assert themselves, often reacting to short-term situational stress-failure, family difficulties, growing pains, etc. After a few days or weeks their behaviors return to normal. This chapter is not about those children; it is about children who are regularly and severely disruptive and violent, exhibiting behaviors month after month that impact the lives of their teachers, peers, and community members. Nearly every teacher has had one or two such children, and hopes never to have another. But as society changes, schools will see more, not less, of these students. This chapter is about the Bobbys in our schools; it is about how to help them and how to help ourselves.

Who These Children Are

It is probably best not to classify violent and disruptive students as behaviorally or emotionally disturbed—though some may be. There is wide disagreement about the definition of these terms. In addition, there is general reluctance on the part of school personnel to use state department of education guidelines since programs for those labeled as behaviorally disordered are very expensive. To classify them obligates the school to provide services either within district or to contract for them from another source. There are also psychiatric categories but these have not typically been useful to school-based helpers.

Incidence figures for violent and disruptive students as a distinct category are not available. Estimates of the number of behavior disordered school-age persons range from about 2 to 10 percent. However, not all of these persons are violent and disruptive. In the author's experience, not more than 1 in 100 is considered violent and disruptive if we concern ourselves with only those who are chronic problems for school personnel and the community. But as society changes such problems will inevitably increase.

Students develop aggression for a variety of reasons. Some come from homes that are in turmoil, with a higher than normal incidence of divorce, physical and sexual abuse, alcohol and chemical abuse, rejection, and inconsistent discipline. They have models for their aggressive ways and are communicating the frustration and distress that builds when one has to endure such conditions for a prolonged time. They are predominantly males in elementary and junior high school. By the time they are of high school age, many have dropped out or are expelled. Teachers are able to informally identify them in the primary grades—and sometimes as early as kindergarten. Most remain in regular classes. When they are in special education, it is usually a program for learning disabled rather than behaviorally disordered students.Genetic, hormonal, and biochemical factors are often used to explain aggressive behaviors. It is popularly believed that aggressive behaviors are inherited or are the result of improperly functioning glands. These may contribute aggression, but most professionals agree that they are not the primary factors. The environment, including the family, school, and community are in all but a small percentage of cases the major cause of such problems.

➤ PREVENTION

Those who have had to contend with such students appreciate the wisdom of an "ounce of prevention." Confrontation with violent and disruptive students is much like doing battle. Though school-based service providers are professionals paid to work with all students, it is extremely taxing and often unnecessary to meet every situation head-on at the intervention level. Prevention should always be preferred to confrontation.

There is no clear delineation between prevention and intervention. A physician with whom the author worked pointed out that taking aspirin could be viewed as both treatment and prevention. It eliminates the present headache as well as prevents one that is worse. Likewise, many of the intervention procedures described in this chapter could be seen in the same way—especially in the case of minimal intrusion techniques discussed later in the intervention section. One general approach to prevention is restructuring the school environment.

Restructuring the School Environment

Some problems can be dealt with by restructuring the school environment so that problem behaviors are less likely to occur. It is much easier to use this approach than to deal with the consequences of not preventing problems.

♦ Plan Ahead

Be prepared when you have "him" in your class. Arrive at school 5 to 10 minutes earlier than usual. This suggestion might sound insignifiant but its importance should not be underestimated. The disruptive student takes advantage of those who are unprepared. Know what your daily routine will be, have well-defined lesson plans, and rehearse your strategies. Easier said than done, but to not be prepared is to invite disaster.

♦ General Modifications

Rearrange the environment to reduce problems. There are a number of easily identified antecedents to disruptive behavior. Teachers know that certain physical conditions in the room can lead to problems. Things to consider are:

SEATING ASSIGNMENT. Locate the disruptive student near those who are least likely to set him off or away from distracting areas of the room. Place him a reasonable distance from peers without obviously attempting separation. The objective is to reduce crowding—not isolate.

HEATING AND LIGHTING. Over-heated rooms can cause troubles. After P.E. or recess on cold days, a hot room might indirectly lead to difficulties. The student becomes tired, sets his assignments aside, and gets into trouble. Lighting should also be considered. Too little can interfere with academic performance. Type of lighting may also be important. Though some educators maintain that fluorescent lights cause hyperactivity, research findings are unclear.

CONTROLLED, PREDICTABLE, AND SUPPORTIVE ENVIRONMENT. "What can we do at school? The family has them most of the day." In fact, between the ages of 6 and 18 the school has students almost as many waking hours as do the parents—12,960 hours. In many cases, the educational system is one of the best sources of support for troubled children and adolescents. It provides a controlled predictable and supportive environment that is more or less consistent over time. A record of assessments and social and educational performance is passed on from year to year and is shared with various school- and community-based helpers. For disruptive and violent students it is especially important that consistent support be provided. He should be regularly reassured that the school really does care about him. He should know the rules and why they exist....

REDUCED EXPECTATIONS. The facts are that most disruptive students will not complete assignments as quickly or correctly as their more normal classmates. Consequently, those who accommodate for this reality can avoid dooming the student to more failure and frustration. This can be accomplished by: (a) reducing the number of problems assigned, (b) allowing him to turn in assignments late, (c) excusing him altogether from some of the more stressful activities, (d) providing extra cues (e.g., showing a few examples of completed problems, printing instructions for assignments on 3 x 5 cards and taping them to the desk, asking if there are any questions), and (e) and encouraging peer assistance.

PRODUCTIVE ACTIVITIES. Ancient admonitions about the tribulations of idle hands should definitely be heeded when working with disruptive students. They are able to turn even the best planned situations into chaos. When left with nothing to do, they will do something—and it often means trouble for the teacher. Problems can be prevented if idle time is held to a minimum. Plan a menu of activities that can be kept on hand. Have available extra seatwork assignments, educational games, or activities that relate to one of their personal interests (if they are legal).

ASSIGN A FRIEND. These students usually do not have many friends. The ones they do have are like those attracted to comedian Rodney Dangerfield—people who can do them no good. School-based helpers could consider assigning a peer to assist the disruptive student during specific times, e.g., academic projects or field trips. This peer should be someone who is accepting and supportive and who is not intimidated by the student. In some cases it may be necessary to assign two peers. In this way they can be reinforcing to each other for working with what their classmates may feel is an "untouchable." Two will also be less intimidated.

HIGH ENERGY ACTIVITIES. Many disruptive and violent students seem to have an excess of energy, especially for doing the wrong things. Some educators believe it is helpful to "burn off" this energy by engaging these students in physical activity prior to more sedentary tasks. An example would be scheduling P.E. before English. However, others reason just the reverse—activity begets activity. If the student is in relaxing situations, he is more likely to be calm; if he is in active situations, he will respond with more activity. The evidence is not clearly supportive of either position. The school-based helper should observe each student to determine which of the two approaches is most likely to apply—and then adjust activities accordingly.

➤ INTERVENTION

What can be done to help these students? The answer varies according to educators' beliefs about the causes of these behaviors. "He's just like his father." "What can you expect from an environment like that?" "All those sweets and food additives are causing it." This section discusses the premises of three models of human behavior and specific intervention techniques. Interventions are presented in order from informal to formal, and from simple to difficult to apply. The classroom is the setting for most of the interventions since there is where the majority of violent and disruptive behaviors occur.

Models

It has been popular professional behavior among educators and psychologists to adhere to particular well-defined models of intervention; e.g., psychodynamic, psychoeducational, or behavioral. With each there are beliefs about the nature of humans and the purpose of their various behaviors. Likewise, there are strategies appropriate to each model. Human behavior is sufficiently complex as to enable each professional group to believe their approach to treatment is most legitimate. The descriptions that follow are presented only to provide school-based helpers with a perspective about various models.

♦ *Psychodynamic Approach*

The psychodynamic approach holds that behavior is fueled by unconscious drives or needs. Abnormal behavior is presumed to be the result of inadequate development in one or more stages. In Freudian psychol-ogy, these are psychosexual stages. The therapist's role is to provide ways for clients to bring into consciousness their repressed desires and needs.

A number of therapists have developed psychotherapeutic approaches for disturbed adolescents. Bettelheim, Redl, and Newman have all taken a psychoanalytic approach to the problems of disturbed children and youth. Each relies to some degree on expression of feelings to deal with disturbed behaviors. This is usually done through creating an atmosphere of permissiveness and trust. Behaviors themselves are viewed as symptoms of the underlying emotional problems.

♦ *Humanistic Approach*

The humanistic approach to treatment of behavioral problems seeks to understand the whole person. It uses procedures for working with troubled children like acceptance and helping the student reflect on his own behavior. As a consequence, the student begins to develop insight and is able to modify his own behavior so that it is more acceptable and self-satisfying. Most humanistic therapists advocate developing an atmosphere within school environments that communicate acceptance, trust, and empathy towards students. Rogers, Gordon, and Axline have all developed humanistic treatment programs that have been used with children and adolescents.

♦ *Behavioral Approach*

The behavioral approach is the most recent therapy to emerge in the schools, though it has been in existence for the past 40 years. Psychologists and educators pioneered its development with severely disturbed and retarded individuals. The basic premise is that behavior is learned. People are, in large measure, developed by the environments in which they are raised. Behavioral approaches require the systematic application of well-defined principles like shaping, reinforcement, extinction, and punishment. The procedures now in general use in public schools include various types of systematic reinforcement systems (e.g., token economies and contracts).

Critics and even some behaviorists maintain that behaviorism does not concern itself with the causes of behavior. Actually, the disagreement is about which are the important causes. Behaviorists accept "here and now" observable causes, while psychodynamic and humanistic therapists accept inner states and distant past events as important. Probably each of the approaches discussed has value with certain students. Fine (1973) has depicted in schematic form a range of therapeutic interventions (see FIgure 1). He states: Behavior change strategies can be distributed roughly on a continuum in terms of the amount of external structuring they possess. Such a distribution is tenuous since individual teachers and psychologists add their own twists to a given procedure. Yet there does seem to be at least a face validity to the chart. For example, the kinds of children involved in totally engineered environments (Hewett, 1968) are extremely disorganized children in terms of behavior control and learning capacity. Their behavior presumably becomes more ordered as a function of the structuring and shaping influences of that environment (p. 69).

Violent and disruptive students are clearly those who exhibit poor self-control, appear impulsive and need externally imposed structure.

Though the intervention techniques discussed are not identified with a single therapeutic approach, they are ones that have been found to be most effective with students who are impulsive and uncontrolled.

School-based helpers are busy and are expected at times to perform a variety of activities concurrently, such as class management and instruction. Consequently, all else being equal, those procedures that are the least time consuming and least difficult to apply are preferred.

Minimal Intrusion Techniques

Techniques will be presented in order of least intrusive, simple to apply to most intrusive, most difficult to apply. The eight techniques discussed below are based on the work of Long and Newman (1965).

♦ *Planned Ignoring*

Some of the things that violent and disruptive students do can be ignored. If their intent is to get attention or provoke a confrontation, the school service provider is, in effect, walking into a trap when he/she attends to attention-getting behaviors. Planned ignoring means that the student's behaviors are intentionally not noticed. For example, the teacher "does not hear" humming, pencil tapping, or the barely uttered threat. For students who are waiting for a chance to blow up or for those whose self-control is so poor that minor infractions of rules are unconscious and inadvertent, the teacher who reacts has unwittingly allowed herself to be slapped across the face with a glove—the duel is on and more problems, not fewer, will ensue.

There are instances that cannot be ignored. A student threatening physical harm to another or being extremely disruptive cannot be ignored by the teacher or his classmates. Planned ignoring is only appropriate for minor infractions. Save your efforts and energy for those things that really matter. Violent and disruptive students provide unlimited opportunities to do battle, so choose wisely what is worth the effort and what is not. This procedure is similar to extinction, which will be discussed later.

Behavioral Characteristics of the Child

Poor self-control	Good self-control
Impulsive-disorganized	Self-controlled, well-organized

Child's Need for Structure

Needs external imposed structure	Manages with self-imposed structure

Illustrative Kinds of Intervention Strategies

		Token economy		Life space interview		Limited communication techniques		Tolerating	
Adult is in control									Child is in control
	Engineered classroom		Contingency management		Reality counseling		Minimal influence Techniques		

Figure 8-1. Matching the Intervention Strategy to the Child.

◆ ***Signal Interference***

Teachers use a wide variety of signals with their typical students. These are especially common in the lower grades. "Lights off" means "I want everyone quiet." Eye contact with most children is sufficient to convey dissatisfaction with their behavior. Signals like these can be used to unobtrusively cue a student to stop performing a disruptive behavior. Many of these techniques are nonverbal and do not need to put the student in an embarrassing position in front of the rest of the class. The teacher can meet privately with the student in order to mutually determine the signal that cues him *not* to engage in disruptive behaviors. Examples of signals that could be used to cue a student are: (a) clearing throat; (b) snapping fingers; (c) ringing a small bell; (d) placing a warning sign on the board, teacher's desk, or student's desk; and (e) using hand gestures (e.g., one finger for strike one," etc.).

◆ ***Proximity Control***

When a teacher casually walks down the aisles in her classroom, misbehaviors tend to decrease and attention increases. On occasion, this technique can also be used with disruptive students just as effectively. The use of touch can also help. This closeness helps the student know that the teacher is interested and concerned. Putting the student's desk near the teacher's can also be effective if it is not perceived as punishment. Some teachers have a desk near theirs that can be used by the disruptive student on an as needed basis. Proximity control can be used in combination with signal interference—sitting closer to the teacher so that she can provide less obtrusive signals. Both procedures alert the student and help him refocus his attention on the appropriate activity.

◆ *Interest Boosting*

It is a challenge to maintain the interest of a disruptive student. It is wise to have available a few topics of interest to be used at the appropriate time. These focus his interest on something appropriate rather than losing him completely because of boredom or disruptiveness. Focusing on something of interest may prevent a costly outburst. A simple and direct procedure is to show interest in the lesson on which the student is currently struggling. Other approaches are to: (a) obtain interesting and unusual facts that can be used during various academic lessons; (b) have available a book of facts to boost interest: e.g., *Guiness Book of Records;* (c) determine areas of interest the disruptive student has and be ready to use them in minor modification of lessons; and (d) use high interest activities that support lessons, such as educational games.

◆ *Use of Humor*

When hostility and aggression are encountered, it is natural to counter with more hostility and aggression. Yet, as many wise leaders have found, tensions can be reduced through humor. Physically, laughter produces a relaxation response.

The school-based helper can use humor to defuse potentially volatile situations and help everyone involved feel less threatened and more comfortable. Miss Wilson was engaged in a heated debate with a student in her class about some problems he did not want to do. In an effort to bring calm to the situation, she used humor. She said, "I don't know the meaning of the word defeat . . . and several thousand other words." Those without a sense of humor are destined to face countless tribulations, especially if they work in a human services profession. Henry Ward Beecher comments, "A person without a sense of humor is like a wagon without springs—jolted by every pebble in the road. " It is especially critical for school-based helpers who serve violent and disruptive students to have a sense of humor. I would not hire one who does not.

◆ *Support from Routine*

One of the most important things the school can do for a student with behavioral problems is to provide a well-defined routine. Predictability and structure, under the supervision of a caring teacher, are extremely important. During the transitions from one activity to another is when most problems occur. Going from reading to art or from math to recess breed problems. These are times when violent and disruptive students wreak havoc on their classmates.

Well-defined schedules prevent problems. Once developed, do not keep them secret—share them with the students. They are especially important for ancillary staff to have and maintain. School-based helpers who cannot be counted on to show up on time lose a significant amount of effectiveness with students who have behavioral problems. These students need a stable and predictable environment.

◆ *Removing Seductive Objects*

The wide variety of high appeal items marketed for children and adolescents, is on occasion, in fierce competition with the teacher. Toy cars and stereos and many other items cause distractions and fights among students. Wise teachers know that such items frequently need to be taken from a student and returned after class. In a later section we will look at how they can be used to improve behavior when contingently returned based on certain predefined conditions having been met...

◆ *Systematic Praise*

One of the least costly and simple to use techniques is systematic praise. Since these students make themselves unpraiseworthy, it is usually necessary to assist teachers and others in establishing a specific system of praise. Many ask, "Why should I reinforce him for what all the other students do normally?" Though there is some validity in this point of view, it is necessary to break the cycle of hostility. School-based helpers can play an important role in this regard...

◆ *Self-management*

Productive self-management is one of the most obvious deficits of violent and disruptive students. They are often described as uncontrolled. The strategies presented above (praise, token systems, contracts, and modeling) are used to help students learn productive behaviors under carefully specified and monitored conditions. After the student begins to behave in a more prosocial fashion under the guidance of a school-based helper, he should be gradually taught self-control techniques.

This training has four components: (a) self-selected behaviors to change, (b) self-determined reinforcements, (c) self-administered reinforcements, and (d) self-monitoring of progress. Students respond surprisingly well to being given control of their own development programs...

Teaching self-management skills is analogous to teaching study skills. Some students seem instinctively to know how to study effectively. Others need to be shown effective techniques. They are amazed to see that these simple procedures work—to them it is almost like cheating. Similarly with self-management, major changes can be made with the consistent application of a few easy-to-learn techniques...

Home-School Cooperation

Disruptive students require close communication between school and home. Disruptiveness can be a reaction to home stress. Aggressiveness may be a way of coping within the family. Working only with the student is not likely to be effective. To modify behavior, the school and home need to be restructured to provide positive experiences for the student. Some are angry at the world and resist assistance—lacking trust in adults. Extraordinary measures may be necessary to build that trust. They may feel neglected and have learned to act out to gain attention. Schools frequently give attention to negative behaviors. Suspension and expulsion do little to teach students what is expected of them. Often they create feelings of anger and blame in students and parents. Below are suggestions for working with the parents:

1. Meet with the parents as soon as possible. Get to know them. Convey your interest in helping their student. Most of their contacts with the school have probably been negative, informing them of what Bill did again today. If they know you and appreciate your professional interest in helping their child, more home-school cooperation is likely.
2. Give the parents advice on things they can do to help their child. Some of the things these students often need from the home are positive attention and praise, protection from parental stresses, rest, a balanced diet, and hygienic care.
3. Set up a home-school communication system to regularly share progress or difficulties the student is experiencing. Weekly phone calls, notes, behavior report cards, or visits to the school can all be helpful.
4. Help parents develop a contract with the student at home. It could address problems that are also being worked on at school. When the school and home are attending to similar behaviors more generalization is likely to occur.
5. Encourage parents to meet with others who are experiencing similar difficulties. Parent groups provide support and offer alternative strategies. The school could help form such a program if one does not exist.

Praise parents for progress their child makes. Being the parent of a troubled child is a difficult task. Recognize the student's progress - or attempts at progress. These positive contacts with the home can be opportunities to help them learn effective child-rearing skills.

➤ REFERENCES

Fine, M.J. (1973). *The teacher's role in classroom management.* Lawrence, KS: Psych-Ed Associates.

Foster, G.G., Ysseldyke, J.E., & Reese, J.H. (1975). "I wouldn't have seen it if I hadn't believed it." *Exceptional Children, 41,* 469-473.

Glasser, W. (1969). *Schools without failure.* New York: Harper & Row.

Long, N.J., & Newman, R.C. (1965). Managing surface behavior of children in school. In N.J. Long, W.C. Morse, & R.C. Newman (Eds.), *Conflict in the classroom.* Belmont, CA: Wadsworth.

Physician's Desk Reference (1985). Oradell, NJ: Medical Economics Company.

Podemski, R.S., Price, B.J., Smith, T.E., & Marsh, G.E. (1984). *Comprehensive administration of special education.* Rockville, MD: Aspen Publication.

Excerpts from:

ADDRESSING STUDENT PROBLEM BEHAVIOR

AN IEP TEAM'S INTRODUCTION TO FUNCTIONAL BEHAVIORAL ASSESSMENT AND BEHAVIOR INTERVENTION PLANS

(2nd edition)
September 16, 1998

Prepared By
The Center for Effective Collaboration and Practice
Mary Magee Quinn, Ph.D., Deputy Director, Center for Effective Collaboration and Practice
Robert A. Gable, Ph.D., Research Fellow; Professor, Old Dominion University
Robert B. Rutherford, Jr., Ph.D., Research Fellow; Professor, Arizona State University
C. Michael Nelson, Ed.D., Research Fellow; Professor, University of Kentucky
Kenneth W. Howell, Ph.D., Research Fellow; Professor, Western Washington University

Readers are encouraged to copy and share it, but please credit this information is copyright free. The Center for Effective Collaboration and Practice.

Educators have long understood that behavior difficulties can keep students from functioning productively in class. Many school personnel have been considering the effects of behavior on learning for some time....

WHY A FUNCTIONAL ASSESSMENT OF BEHAVIOR IS IMPORTANT

Although professionals in the field hold a variety of philosophical beliefs, they generally agree that there is no single cause for problem behaviors...

To illustrate this point, again consider the acting-out behaviors previously described. Reactive procedures, such as suspending each student as a punishment for acting-out, will only address the symptoms of the problem, and will not eliminate the embarrassment. . . Therefore, each of these behaviors are likely to occur again, regardless of punishment, unless the underlying causes are addressed.

Functional behavioral assessment is generally considered to be an approach that incorporates a variety of techniques and Strategies to diagnose the causes and to identify likely interventions intended to address problem behaviors. In other words, functional behavioral assessment looks beyond the overt topography of the behavior, and focuses, instead, upon identifying biological, social, affective, and environmental factors that initiate, sustain, or end the behavior in question. This approaches important because it leads the observer beyond the "symptom" (the behavior) to the student's underlying motivation to escape, avoid," or "get" something (which is, to the tractional analyst, the root of all behavior).Research and experience have demonstrated that behavior intervention plans stemming from the knowledge of *why* a student misbehaves (i.e., based on a functional behavioral assessment) are extremely useful addressing a wide range of problems.

The functions of behavior are not usually considered inappropriate. Rather, it is the behavior itself that is judged appropriate or inappropriate. For example, getting high grades and acting-out may serve the same function (i.e., getting attention from adults), yet the behaviors that lead to good grades are judged to be more appropriate then those that make up acting-out behavior...

IDENTIFYING THE PROBLEM BEHAVIOR

Before a functional behavioral assessment can be implemented, it is necessary to pinpoint the behavior causing learning or discipline problems, and to define that behavior in concrete terms that are easy to communicate and simple to measure and record. If descriptions of behaviors are vague (e.g. poor attitude), it is difficult to determine. . .

It may be necessary to carefully and objectively observe the student's behavior in different settings and during different types of activities, and to conduct interviews with other school staff and care givers, in order to pinpoint the specific characteristics of the behavior.

Once the problem behavior has been defined concretely, the team can begin to devise a plan for conducting a functional behavioral assessment to determine functions of the behavior. The following discussion can be used to guide teams in choosing the most effective techniques to determine the likely causes of behavior.

POSSIBLE ALTERNATIVE ASSESSMENT STRATEGIES

The use of a variety of assessment techniques should lead teams to better understand student behavior. Each technique can, in effect, bring the team closer to developing a workable intervention plan.

A well developed assessment plan and a properly executed functional behavioral assessment should identify the contextual factors that contribute to behavior. Determining the specific contextual factors for a behavior is accomplished by collecting information on the various conditions under which a student is most and least likely to be a successful learner. That information, collected both indirectly and directly, allows school personnel to predict the circumstances under which the problem behavior is likely and not likely to occur.

Multiple sources and methods are used for this kind of assessment, as a single source of information generally does not produce sufficiently accurate information, especially if the problem behavior serves several functions that vary according to circumstance (e.g., making inappropriate comments during lectures may serve to get peer attention in some instances, while in other situations it may serve to avoid the possibility of being called on by the teacher).

It is important to understand, though, that contextual factors are more than the sum of observable behaviors, and include certain affective and cognitive behaviors, as well. In other words, the trigger, or antecedent for the behavior, may not be something that anyone else can directly observe, and, therefore, must be identified using indirect measures. For instance, if the student acts out when given a worksheet, it may not be the worksheet that caused the acting-out, but the fact that the student does not know what is required and thus anticipates failure or ridicule. Information of this type may be gleaned through a discussion with the student.

Since problem behavior stems from a variety of causes, it is best to examine the behavior from as many different angles as possible. Teams, for instance, should consider what the "pay-off" for engaging in either inappropriate or appropriate behavior is, or what the student "escapes," "avoids," or "gets" by engaging in the behavior. This process should identify workable techniques for developing and conducting functional behavioral assessments and developing behavior interventions. When considering problem behaviors, teams might ask the following questions.

Is the problem behavior linked to a skill deficit?

Is there evidence to suggest that the student does not know how to perform the skill and, therefore cannot? Students who lack the skills to perform expected tasks may exhibit behaviors that help them avoid or escape those tasks. If the team suspects that the student "can't" perform the skills, or has a skid deficit. They could devise a functional behavioral assessment plan to determine the answers to further questions, such as the following:

- Does the student understand the behavioral expectations for the situation?
- Does the student realize that he or she is engaging in unacceptable behavior, or has that behavior simply become a "habit"?
- Is it within the student's power to control the behavior, or does he or she need support?
- Does the student have the skills necessary to

perform expected, new behaviors?

Does the student have the skill,, but, for Some reason, not the desire to modify his or her behavior?

Sometimes it may be that the student can perform a skill, but, for some reason, does not use it consistently (e.g., in particular settings). This situation is often referred to as a "performance deficit." Students who can, but do not perform certain tasks may be experiencing consequences that affect their performance (e.g., their non-performance is rewarded by peer or teacher attention, or performance of the task is not sufficiently rewarding). If the team suspects that the problem is a result of a performance deficit, it may be helpful to devise an assessment plan that addresses questions such as the following:

- Is it possible that the student is uncertain about the appropriateness of the behavior (e.g., it is appropriate to clap loudly and yell during sporting events, yet these behaviors are often inappropriate when playing academic games in the classroom)?
- Does the student find any value in engaging in appropriate behavior?
- Is the behavior problem associated with certain social or environmental conditions?
- Is the student attempting to avoid a "low-interest" or demanding task?
- What current rules, routines, or expectations does the student consider irrelevant?

TECHNIQUES FOR CONDUCTING THE FUNCTIONAL BEHAVIORAL ASSESSMENT

Indirect assessment. *Indirect* or *informant assessment* relies heavily upon the use of structured interviews with students, teachers, and other adults who have direct responsibility for the students concerned. Individuals should structure the interview so that it yields information regarding the questions discussed in the previous section, such as:

- In what settings do you observe the behavior?
- Are there any settings where the behavior does not occur?
- Who is present when the behavior occurs?
- What activities or interactions take place just prior to the behavior?
- What usually happens immediately after the behavior?
- Can you think of a more acceptable behavior that might replace this behavior?

Interviews with the student may be useful in identifying how he or she perceived the situation and what caused her or him to react or act in the way they did. Examples of questions that one may ask include:

- What were you thinking just before you threw the textbook?
- How did the assignment make you feel?
- Can you tell me how Mr. Smith expects you to contribute to class lectures?
- When you have a "temper tantrum" in class, what usually happens afterward?

Commercially available student questionnaires, motivational scales, and checklists can also be used to structure indirect assessments of behavior. The district's school psychologist or other qualified personnel can be a valuable source of information regarding the feasibility of using these instruments.

Direct assessment. *Direct assessment* involves observing and recording situational factors surrounding a problem behavior (e.g., *antecedent* and *consequent* events). An evaluator may observe the behavior in the setting that it is likely to occur, and record data using an Antecedent-Behavior-Consequence (ABC) approach. (Appendix A shows two examples of an ABC recording sheet.)

The observer also may choose to use a *matrix* or *scatter plot* to chart the relationship between specific instructional variables and student responses. (See Appendix B for examples.) These techniques also will be useful in identifying possible environmental factors (e.g., seating arrangements), activities (e.g., independent work), or temporal factors (e.g., mornings) that may influence the behavior. These tools can be developed specifically to address the type of variable in question, and can be customized to analyze specific behaviors and situations (e.g., increments of 5 minutes, 30 minutes, 1 hour, or even a few days).

Regardless of the tool, observations that occur consistently across time and situations, and that reflect both quantitative and qualitative measures of the behavior in question, are recommended.

Data analysis. Once the team is satisfied that enough data have been collected, the next step is to compare and analyze the information. This analysis will help the team to determine whether or not there are any patterns associated with the behavior (e.g., whenever Trish does not get her way, she reacts by hitting someone). If patterns cannot be determined, the team should review and revise (as necessary) the functional behavioral assessment plan to identify other methods for assessing behavior.

Hypothesis statement. Drawing upon information that emerges from the analysis, school personnel can establish a hypothesis regarding the function of the behaviors in question. This hypothesis predicts the general conditions under which the behavior is most and least likely to occur (antecedents), as well as the probable consequences that serve to maintain it. For instance, should a teacher report that Lucia calls out during instruction, functional behavioral assessment might reveal the function of the behavior is to gain attention (e.g., verbal approval of classmates), void instruction (e.g., difficult assignment), seek excitement (i.e., external stimulation), or both to gain attention and avoid a low-interest subject.

Only when the relevance of the behavior is known is it possible to speculate about the true function of the behavior and establish an individual behavior intervention plan. In other words, before any plan is set in motion, the team needs to formulate a plausible explanation *(hypothesis)* for the student's behavior. It is then desirable to manipulate pious conditions to verify the assumptions made by the team regarding the function the behavior...

BEHAVIOR INTERVENTION PLANS

After collecting data on a student's behavior, and after developing a hypothesis of the likely function of that behavior, a team develops (or revises) the student's behavior intervention plan or strategies in the IEP. These may include positive strategies, program or curricular modifications, and supplementary aids and supports required to address the disruptive behaviors in question. It is helpful to use the data collected during the functional behavioral assessment to develop the behavior intervention plan or strategies and to determine the discrepancy between the child's actual and expected behavior.

The input of the general education teacher, as appropriate (i.e., if the student is, or may be participating in the regular education environment), is especially crucial at this point. He or she will be able to relay to the team not only his or her behavioral expectations, but also valuable information about how the existing classroom environment and/or general education curriculum can be modified to support the student.

Intervention plans and strategies emphasizing skills students need in order to behave in a more appropriate manner, or plans providing motivation to conform to required standards, will be more effective than plans that simply serve to *control* behavior. Interventions based upon *control* often fail to generalize (i.e., continue to be used for long periods of time, in many settings, and in a variety of situations)—and many times they serve only to *suppress* behavior—resulting in a child manifesting unaddressed needs in alternative, inappropriate ways. Positive plans for behavioral intervention, on the other hand, will address both the source of the problem and the problem itself....

ADDRESSING SKILL DEFICITS

An assessment might indicate the student has a *skill deficit* and does not know how to perform desired skills. The functional behavioral assessment may show that, although ineffective, the child may engage in the inappropriate behavior to escape or avoid a situation: (1) for which he or she lacks the appropriate skills; or (2) because she or he lacks appropriate, alternative skills and truly believes this behavior is effective in getting what he or she wants or needs. For example, a child may engage in physically violent behavior because he or she believes violence is necessary to efficiently end the confrontational situation, and may believe that these behaviors will effectively accomplish his or her goals. However, when taught to use appropriate problem-solving techniques, the student will be more likely to approach potentially volatile situations in a nonviolent manner. If this is the case, the intervention may address that deficit by including, within the larger plan, a description of how to teach the problem-solving skills needed to support the child. . . .

ADDRESSING PERFORMANCE DEFICITS

If the functional behavioral assessment reveals that the student knows the skills necessary to perform the behavior, but does not consistently use them, the intervention plan may include techniques, strategies, and supports designed to increase motivation to perform the skills.

If the assessment reveals that the student is engaging in the problem behavior because it is more desirable (or reinforcing) than the alternative, appropriate behavior, the intervention plan could include techniques for making the appropriate behavior more desirable. For instance, if the student makes rude comments in class in order to make her peers laugh, the plan might include strategies for rewarding appropriate comments as well as teaching the student appropriate ways to gain peer attention. *Behavioral contracts or token economies* and other interventions that include peer and family support may be necessary in order to change the behavior.

ADDRESSING BOTH SKILL AND PERFORMANCE DEFICITS

Some student problems are so significant they require a combination of techniques and supports. For example, if the student finds it difficult to control his or her anger, she or he may need to be taught certain skills, including the following:

- recognize the physical signs that he or she is becoming angry,
- use relaxation skills,
- apply problem-solving skills, and
- practice communication skills;

and have the added support of:

- the school counselor,
- the school psychologist, and
- curricular or environmental modifications.

In addition, the student may need to be provided with external rewards for appropriately dealing with anger.

Many professionals and professional organizations agree that it is usually ineffective and often unethical to use *aversive* techniques to control behaviors, except in very extreme cases, such as situations in which:

- the child's behavior severely endangers her or his safety or the safety of others,
- every possible positive intervention has been tried for an appropriate length of time and found ineffective, and
- the behavior of the student severely limits his or her learning or socialization, or that of others.

MODIFYING THE LEARNING ENVIRONMENT

In addition to factors of skill and motivation, the functional behavioral assessment may reveal conditions within the learning environment, itself, that may precipitate problem behavior. Factors that can serve as precursors to misbehavior range from the physical arrangement of the classroom or student seating assignment to academic tasks that are "too demanding" or "too boring." Again, simple curricular or environmental modifications may be enough to eliminate such problems.

Providing Supports

Sometimes *supports* are necessary to help students use appropriate behavior. The student, for example, may benefit from work with school personnel, such as counselors or school psychologists. Other people who may provide sources of support include:

- Peers, who may provide academic or behavioral support through tutoring or conflict-resolution activities, thereby fulfilling the student's need for attention in appropriate ways;
- Families, who may provide support through setting up a homework center in the home and developing a homework schedule;
- Teachers and paraprofessionals, who may provide both academic supports and curricular

modifications to address and decrease a student's need to avoid academically challenging situations: and

- Language pathologists, who are able to increase a child's expressive and receptive language skills, thereby providing the child with alternative ways to respond to any situation

Whatever the approach, the more proactive and inclusive the behavior intervention plan -and the more closely it reflects the results of the functional behavioral assessment - the more likely that it will succeed. In brief, one's options for positive behavioral interventions may include:

- Replacing problem behaviors with appropriate behaviors that serve the same (or similar) function as inappropriate ones;
- Increasing rates of existing appropriate behaviors;
- Making changes to the environment that eliminate the possibility of engaging in inappropriate behavior; and
- Providing the supports necessary for the child to use the appropriate behaviors.

Care should be given to select a behavior that likely will be elicited by and reinforced in the natural environment, for example, using appropriate problem-solving skills on the playground will help the student stay out of f the principal's office.

EVALUATING THE BEHAVIOR INTERVENTION PLAN

It is good practice for IEP teams to include two evaluation procedures in an intervention plan: one procedure designed to monitor the faithfulness with which the management plan is implemented, the other designed to measure changes in behavior. . . .

RESOURCES

Because there are many resources available to help in the development and implementation of effective behavior intervention plans, the following are simply a sampling of possible sources of information:

Alberto, P.A., & Troutman, A.C. (1995). Applied behavior analysis for teachers (4th ed.). Englewood Cliffs, NJ: Merrill/Prentice-Hall.

Bullock, L.M., & Gable, R.A. (Eds.) (1997). Making collaboration work for children, youth, families, schools, and communities. Reston, VA: Council for Children with Behavioral Disorders & Chesapeake Institute.

Carr, E. G., Robinson, S., & Polumbo, L. W. (1990). The wrong issue: Aversive versus nonaversive treatment. The right issue: Functional versus nonfunctional treatment. In A. Repp & N. Singh (Eds.), Aversive and nonaversive treatment: The great debate in developmental disabilities (pp. 361-380). DeKalb, IL: Sycamore Press.

Carr, E. G., & Durand, V. M. (1985). Reducing behavior problems through functional communication training. Journal of Applied Behavior Analysis, 18 111-126.

Cooper, L. J., Wacker, D. P., Thursby, D., Plagmann, L. A., Harding, J., Millard, T., & Derby, M. (1992). Analysis of the effects of task preferences; task demands, and adult attention on child behavior in outpatient and classroom settings. Journal of Applied Behavior Analysis, 2S, 823-840.

Donnellan, A. M., Mirenda, P. L., Mesaros, R. A., & Fassbender, L. L. (1984). Analyzing the communicative functions of aberrant behavior. Journal of The Association of Persons with Severe Handicaps, 9, 201-212.

Dunlap, G., Kem, L, dePerczel, M., Clarke, S., Wilson, D., Childs, KE., White, R., & Falk, G. D. (1993). Functional analysis of classroom variables for students with emotional and behavioral disorders. Behavioral Disorders, 18, 275-291.

Durand, V. M. (1990). Severe behavior problems: A functional communication training approach. New York: Guilford.

Durand, V. M. (1993). Functional assessment and functional analysis. In M. D. Smith (Ed.). Behavior modification for exceptional children and youth. Boston: Andover Medical Publishers.

Durand, V. M., & Crimniins, D. B. (1988). Identifying the variables maintaining self-injurious behavior. Journal of Autism and Developmental Disorders, 18, 99-117.

Fuchs, D., Fuchs, L., & Bahr, M. (1990). Mainstream assistant teams: A scientific basis for the art of consultation. Exceptional Children, 57, 128-139.

Gable, R. A. (1996). A critical analysis of functional assessment: Issues for researchers and practitioners. Behavioral Disorders, 22, 36-40.

Gable, R. A., Sugai, G. M., Lewis, T. J., Nelson, J. R., Cheney, D., Safran, S. P., & Safran, J. S. (1997). Individual and systemic approaches to collaboration and consultation. Reston, VA: Council for Children with Behavioral Disorders.

Gresham, F.M. (1991). Whatever happened to functional analysis in behavioral consultation? Journal of Educational and Psycholozical Consultation, 2, 387-392.

Haynes, S. N., & O"Brien, W. H. (1990) Functional analysis in behavior therapy. Clinical Psycholo.sv Review, 10, 649-668.

Hendrickson, J. M., Gable, R. A., Novak, C., & Peck, S. (1996). Functional assessment for teaching academics.

Education and Treatment of Children. 19. 257-271.

Homer, R. H., & Day, H. M. (1991). The effects of response efficiency on functionally equivalent competing behaviors. Journal of Applied Behavior Analysis. 24. 719-732.

Homer, R. H., Sprague, J. R., O"Brien, M., & Heathfield, L. T. (1990). The role of response efficiency in the reduction of problem behaviors through functional equivalence training. Journal of the Association for Persons with Severe Handicaps. 15, 91-97.

Iwata, B. A., Vollmer, T. R., & Zarcone, J. R. (1990). The experimental (functional) analysis of behavior disorders: Methodology, applications, and limitations. In A. C. Repp & N. Singh (Eds.), Aversive and nonaversive treatment: The great debate in developmental disabilities (pp. 301-330). DeKalb, L: Sycamore Press.

Kaplan, J.S. (with Carter, J.) (1995). Beyond behavior modification: A cognitive-behavioral approach to behavior management in the school (3rd edition). Austin, TX: Pro-Ed.

Karsh, K. G., Repp, A. C., Dahlquist, C. M., & Munk, D. (1995). in vivo functional assessment and multi-element interventions for problem behaviors of students with disabilities in classroom settings. Journal of Behavioral Education. 5, IS9-210.

Kerr, M.M., & Nelson, C.M. (1998). Strategies for managing behavior problems in the classroom (3rd edition). New York: MacMillan.

Lawly, J. R., Storey, K, & Danko, C. D. (1993). Analyzing behavior problems in the classroom: A case study of functional analysis. Intervention in the School and Clinic. 29, 9S100.

Lewis, T. J. (1997). Teaching students with behavioral difficulties. Reston, VA: Council for Exceptional Children.

Lewis, T. J., Scott, T. M., & Sugai, G. M. (1994). The problem behavior questionnaire: A teacher-based instrument to develop functional hypotheses of problem behavior in general education classrooms. Diagnostique. 19, 103-115.

Lewis, T. J., & Sugai, G. M. (1994). Functional assessment of problem behavior: A pilot investigation of the comparative and interactive effects of teacher and peer social attention on students in general education settings. School Psychology Quarterly 11, 1-19.

Long, N., & Morse, W.C. (1996). Conflict in the classroom. Austin, TX: Pro-Ed.

Lovaas, O. I., Freitag, G., Gold, V. J., & Kassorla, L. C. (1965). Experimental studies in childhood schizophrenia: Analysis of self-destructive behavior. Journal of Experimental Child Psychology 2, 67-84.

Mathur, S. R., Quinn, M .M., & Rutherford, R.B. (1996). Teacher-mediated behavior management strategies for children with emotional/behavioral disorders. Reston, VA: Council for Children with Behavioral Disorders.

Pierce, W. D., & Epling, W. F. (1980). What happened to the analysis in applied behavior analysis? The Behavior Analyst. 3, 1-10.

Reed, H., Thomas, E., Sprague, J. R., & Homer, R. H. (1997). Student guided functional assessment interview: An analysis of student and teacher agreement. Journal of Behavioral Education. 7, 3349.

Rutherford, R.B., Quinn, M.M., & Mathur, S.R. (1996). Effective strategies for teaching appropriate behaviors to children with emotional/behavioral disorders. Reston, VA: Council for Children with Behavioral Disorders.

Sasso, G. M., Reimers, T. M., Cooper, L. J., Wacker, D., & Berg, W. (1992). Use of descriptive and experimental analyses to identify the functional properties of aberrant behavior in school settings. Journal of Applied Behavior Analysis. 25, 809-821.

Schmid, R. E., & Evans, W. H. (1997). Curriculum and instruction practices for students with emotional/behavioral disorders. Reston, VA: Council for Children with Behavioral Disorders.

Sugai, G. M., Bullis. M., & Cumblad, C. (1997). Skill development and support of educational personnel. Journal of Emotional and Behavioral Disorders. 5, 55 64.

Sugai, G. M., & Lewis, T. J. (1996). Preferred and promising practices for social skill instruction. Focus on Exceptional Children. 29, 1-16.

Sugai, G. M., tic Tindal, G. A. (1993). Effective school consultation: An interactive approach. Pacific Grove, CA: BrookstCole.

Touchene, P. E., MacDonald, R. F., & Idnger, S. N. (1985). A scatter plot for identifying stimulus control of problem behavior. Journal of Applied Behavior Analysis. 18, 343-351.

Walker, H. M., Colvin, G., & Ramsey, E. (1995). Antisocial behavior in school: Strategies and best practices. Pacific Grove, CA: BrookstCole.

Wood, F. M. (1994). May I ask you why you are hitting yourself? Using oral self-reports in the functional assessment of adolescents' behavior disorders. Preventing School Failure. 38, 16-20.

Behavior Management in Inclusive Classrooms

A popular approach for working with youngsters with behavioral problems in classrooms was summarized in an article entitled Behavior Management in Inclusive Classrooms, which appeared in *Remedial and Special Education, Vol 17* (4), July , 1996, by Stephanie L. Carpenter and Elizabeth McKee-Higgins. The following excerpt from her article captures the idea of this approach.

A primary measure of effectiveness for instructional programs is student academic achievement. However, teachers identify behavioral dimensions as a high priority for the success of students with disabilities and students at risk for school failure in general education classrooms—often as a higher priority than academic skills (Blanton, Blanton, & Cross, 1994; Ellett, 1993; Hanrahan, Goodman, & Rapagna, 1990; Mayer, Mitchell, Clementi, Clement-Robertson, Myatt, & Bullara, 1993). Indeed, students' behaviors during instruction may impact the classroom climate and the extent to which all students are actively engaged in instruction, an indicator of achievement outcomes (Christenson, Ysseldyke, & Thurlow, 1989). A classroom climate characterized by learning and cooperative interactions with groups of students who are motivated, responsive to traditional authority figures and systems (e.g., teachers and schools), and compliant with established rules and routines may be jeopardized by the presence of students who have not learned or adopted behaviors that are compatible with performing within a classroom community of learners. At times the misbehavior of one student or a small group of students seems to spread to other students even when classwide or schoolwide behavioral expectations are established and communicated to students (Smith & Rivera, 1995). When teachers take excessive time to respond to inappropriate student behaviors, valuable instructional momentum and time may be lost. As the diversity of students' characteristics within classrooms increases, the need increases for classroom behavior management systems that are responsive to group and individual student characteristics (Lewis, Chard, & Scott, 1994).

The purpose of this article is twofold. First, proactive behavior management programs are described as an effective means to respond to diverse behavioral characteristics among all students, both those with and without disabilities. Second, one teacher's experiences are described; she incorporated components of a proactive behavior management plan to address both her students' and her own behaviors in order to minimize the negative impact of students' misbehavior on instruction and achievement. An underlying premise is that it is by changing their own behaviors that teachers may have the greatest impact on their students' classroom behaviors.

PROACTIVE BEHAVIOR MANAGEMENT PROGRAMS

Traditional approaches to managing problem behavior have not been responsive to the behavioral and learning characteristics of students with chronic behavior problems (Colvin, F Kameenui, & Sugai, 1993). Despite evidence that effective discipline programs recognize and reward appropriate behavior to promote a positive school climate (Colvin et al., 1993; Mayer et al., 1993), many school or classroom management procedures are reactive, punitive, or control oriented (Colvin et al., 1993; Reitz, 1994). The assumption is that punishment will change behavior in desirable directions. Colvin et al. stated:

> To manage behavior school discipline plans typically rely on reprimands, penalties, loss of privileges, detention, suspension, corporal punishment, and expulsion. By experiencing these reactive consequences it is assumed that students will learn the "right way" of behaving and be motivated sufficiently to comply to the expectations of the school. (p. 364)

Conversely, *effective behavior management programs* that are responsive to individual and group behaviors for classroom or school interactions and participation *are proactive* in nature. Proactive behavior management programs

- Use instructional techniques to develop desired behaviors;
- Promote a positive climate to motivate students;
- Are dynamic and responsive to students' changing behavioral skills; and
- Use collegial interactions to support teachers' use of effective procedures.

Instructional Approach

In an instructional (Colvin et al., 1993) or educative (Reitz, 1994) approach to addressing behavior management, educators view students' participation and interaction behaviors in a way that is similar to their view of students' academic behaviors. The focus is on providing students with structured opportunities to learn and practice desirable behaviors rather than using negative consequences to eliminate undesirable behaviors. The main components of an instructional approach to behavior management include "teaching objectives, explanation of procedures, practice activities, prompts, reinforcement, feedback, and monitoring" (Colvin et al., 1993, p. 366). Colvin and his colleagues developed a model for addressing chronic behavior problems that parallels instruction to remediate chronic academic problems. In this model, teachers (a) identify the functional relationships between behavior and the environment, (b) identify expected or acceptable behaviors, (c) modify the environment so that students can practice expected behaviors in the absence of stimuli that are likely to elicit the inappropriate behavior, (d) reinforce correct responding by using differential reinforcement, and (e) move toward less restrictive or more naturally occurring programming to foster generalization and maintenance of acceptable behaviors.

* * *

Positive Climate

A positive learning climate is one in which the classroom environment is a desirable place to work and to interact with others. For some students, school is not a pleasant place to be because they engage in behaviors that are viewed as undesirable in the classroom environment. When these undesirable behavior patterns are coupled with academic difficulties, a cycle of school failure often emerges that leads many students to stay away from school or ultimately to drop out. Redesigning behavior management programs to create environments that are more desirable places in which to learn should promote greater student motivation to participate in school programs (Dunlap et al., 1993; Mayer et al., 1993). Teachers enhance the learning climate when they recognize the desirable aspects of students' behaviors and structure the classroom environment to facilitate productive work habits and positive interpersonal interactions.

* * *

Reitz (1994) proposed a model for designing comprehensive classroom-based programs for students with emotional and behavioral problems that also included academic and behavioral techniques. Of 10 components presented as essential, five directly or indirectly addressed the creation of a positive class climate:

1. Consistent classroom schedule and structure in which rules, expectations, consequences, and routines are clearly communicated to

students and consistently followed by the teacher. Students may be involved in developing classroom procedures. The teacher should maintain positive focus by emphasizing desired behaviors and their consequences.

2. High rates of student academic involvement and achievement in which the curriculum (content) and instructional delivery (teacher behavior) focus on high rates of student engagement during instruction and practice.

3. High rates of social reinforcement from teachers to promote the learning of new behaviors. Teachers' use of approval statements is an effective teaching tool.

4. System to ensure high rates of tangible reinforcement in which points or "tokens" are given immediately following the occurrence of a desired student behavior and exchanged later by the student to obtain predetermined privileges, activities, or items.

5. A repertoire of teacher responses to mild disruptive behavior that keeps minor problems from escalating into major ones. Combinations of praise for appropriate behavior and ignoring of inappropriate behavior (e.g., differential reinforcement) are effective in maintaining a focus on the positive.

Teachers promote a positive class climate by structuring the learning environment, emphasizing the desirable aspects of students' behaviors, and engaging in positive interpersonal interactions with all students. Both an instructional orientation and a positive classroom climate are necessary in order for behavioral interventions to be dynamic and responsive to students' changing behavioral skills.

Dynamic and Responsive Interventions

Effective behavior management programs are dynamic processes whereby teachers adjust interventions in response to students' changing behaviors. The premise is that behavior management systems, while maintaining a positive orientation, should impose only as much teacher or outside influence as is necessary to achieve desirable student behaviors and a positive learning climate. Knowing "how much is enough" is a function of experience and knowing students' behavioral characteristics. However, when teachers are faced with classrooms composed of diverse student populations, beginning with more structure paired with ample reinforcement and moving toward less permits teachers the opportunity to set the stage for desirable student behaviors early on.

* * *

Collegial Interactions

Collegial interactions serve two primary purposes during the development and implementation of proactive behavior management systems: (a) support for changes in teacher behaviors and (b) programming consistency. Strong collaborative relationships among school staff facilitates commitment to developing, implementing, and maintaining schoolwide plans for proactive behavior management programs (Colvin et al., 1993; Mayer et al., 1993; Reitz, 1994). Cheney and Harvey (1994) found that teachers desired consultations and feedback so that they could ensure that they were making correct decisions. Indeed, understanding behavioral interventions is a prerequisite for effective implementation (Reimers, Wacker, & Koeppl, 1987). Other teachers, administrators, support personnel, or university faculty may provide ongoing feedback, dialogue, and assistance for teachers as they attempt to adapt their behavior management practices (Dettmer, Thurston, & Dyck, 1993; Idol, Nevin, & Paolucci-Whitcomb, 1994). Reimers et al. reported that teachers who implement behavioral programs proficiently and experience benefits in terms of improved student behaviors rate behavioral interventions as more acceptable and are more likely to use them consistently. Taken together, the research suggests that collegial relationships can influence the success teachers experience with behavior management systems, the consistency of implementation, and ultimately the effectiveness of the program.

* * *

The Problem: Looking Deeper

We used a four-step approach to gather information and arrow the scope of the problem:

1. Determine when behaviors seem to present the greatest barrier to instruction and learning.

2. Determine which behaviors are most problematic and identify alternative behaviors that are desired.

3. Identify teacher, classmate, or environmental variables that precede and/or follow the undesired and desired behaviors.

4. Collect data on student and teacher behaviors.

Synthesizing information about the problem proved helpful in identifying patterns associated with the inappropriate behaviors. Patterns of student behaviors and teacher responses emerged that were useful in designing a comprehensive intervention.

* * *

CONCLUSIONS

For many educators the prospect of educating children with disabilities (and possibly a greater variability of behavioral challenges) in general education classrooms is daunting when (a) the numbers of students in classes are increasing, (b) behavior management procedures are taxed by the range of unacceptable behaviors exhibited by students without disabilities, and (c) supports for using new teaching practices are minimal. From such a perspective, undesirable student behavior is viewed as the *problem* within classrooms and schools. An alternative perspective is to view student behavior as integrally related to the context of the classrooms and schools. In other words, a more fundamental consideration may be the way educators respond to students' behaviors, both desirable and undesirable. The "instructional" methods used, class climate created, individuality supported, and collegiality practiced by educators can significantly influence the behavioral and achievement outcomes for the individual child.

Several lessons emerged as young students with disabilities were included in a first-grade classroom. First, when behavior management procedures only marginally (and perhaps negatively) address the behaviors of students without disabilities, including students with disabilities may amplify existing problems. Proactive behavior management programs that are systematically and thoughtfully implemented provide structure and reinforcement that is beneficial for the class as well as the individual child. Second, even though educators may already know about behavior management methods that work, sometimes individual teachers are too close to challenging classroom situations to see clearly what is happening. The collaboration and encouragement of a trusted colleague, or just seeing things through a different lens, can lead to improved outcomes for students and teachers. A final related issue may be the importance of intensive and appropriate intervention at a young age for students, with and without disabilities, who may be at the beginning of a cycle of school failure. Traditionally, the response has been to place such students in separate classes or programs without consideration for how the current environment might be modified and whether modifications are implemented effectively. However, as teachers are encouraged and supported to use known, effective practices in order to be more responsive to all students' learning characteristics, the focus for managing students' behaviors may shift (a) from *where* interventions occur to *what* interventions are effective and (b) from viewing ***students as the problem*** to viewing ***educators as the solution.*** ■

STEPHANIE L. CARPENTER, PhD, is an assistant professor in special education at Johns Hopkins University. Her research interests include practices that promote self-determination for individuals with disabilities. ELIZABETH McKEE-HIGGINS, MS, is a first-grade teacher at Viers Mill Elementary School in Montgomery County Public Schools, Maryland. Her interests include educating elementary-age students with disabilities in general education classrooms while promoting success for all students. Address: Stephanie L. Carpenter, Johns Hopkins University, 9601 Medical Center Dr., Rockville, MD 20850.

AUTHORS' NOTE

The work reported in this article was supported, in part, by Grant No. H029B 10099-92, awarded to Johns Hopkins University from the U.S. Department of Education. However, its content does not necessarily represent the policy of that agency, and no endorsement by the federal government should be inferred.

REFERENCES

Alberto, P. A., & Troutman, A. C. (1990). *Applied behavior analysis for teachers* (3rd ed.). Columbus, OH: Merrill.

Blanton, L. P., Blanton, W. E., & Cross, L. E. (1994). An exploratory study of how general and special education teachers think and make instructional decisions about students with specialneeds. *Teacher Education and Special Education*, 17, 62-74.

Cheney, D., & Harvey, V. S. (1994). From segregation to inclusion: One district's program changes for students with emotional/behavioral disorders. *Education and Treatment of Children*, 17, 332-346

Christenson, S. L., Ysseldyke, J. E., & Thurlow, M. L. (1989). Critical instructional factors for students with mild handicaps: An integrative review. *Remedial and Special Education, 10*(5), 21-31.

Clark, L. A., & McKenzie, H. S. (1989). Effects of self-evaluation training of seriously emotionally disturbed children on the generalization of their rule following and work behaviors across set-tings and teachers. *Behavioral Disorders, 14*, 89-98.

Cob, C. L., & Bambara, L. M. (1992). Issues surrounding the use of self-management interventions in the schools. *School Psychology Reviews 21*, 193-201.

Colvin, G., Kameenui, E. J., & Sugai, G. (1993). Reconceptualizing behavior management and schoolwide discipline in general education. *Education and Treatment of Children, 16*, 361-381.

Dettmer, P., Thurston, L. P., & Dyck, N. (1993). *Consultation, collaboration, and teamwork for students with special needs.* Boston: Allyn & Bacon.

Dunlap, G., Kem, L., dePerczel, M., Clarke, S., Wilson, D., Childs. K. E., White, R., & Falk, G. D. (1993). Functional analysis of classroom variables for students with emotional and behavioral disorders. *Behavioral Disorders, 18*, 275-291.

Ellett, L. (1993). Instructional practices in mainstreamed secondary classrooms. *Journal* of *Learning Disabilities, 26*, 57-64.

Hanrahan, J., Goodman, W., & Rapagna, S. (1990). Preparing mentally retarded students for mainstreaming: Priorities of regular class and special school teachers. *American Journal on Mental Retardation, 94*, 470-474.

Hughes, C. A., Korinek, L., & Gorman, J. (1991). Self-management for students with mental retardation in public school settings: A research review. *Education and Training in Mental Retardation*, 26, 271-291.

Idol, L., Nevin, A., & Paolucci-Whitcomb, P. (1994). *Collaborative consultation* (2nd ed.). Austin, TX: PRO-ED.

Kern, L., Dunlap, G., Childs, K. E., & Clarke, S. (1994). Use of a classwide self-management program to improve the behavior of students with emotional and behavioral disorders. *Education and Treatment of Children*, 1 7, 445-458.

Lewis, T. J., Chard, D., & Scott, T. M. (1994). Full inclusion and the education of children and youth with emotional and behavioral disorders. *behavioral Disorders, 19*, 277-293.

Mayer, G. R., Mitchell, L. K., Clementi, T., Clement-Robertson, E., Myatt, R., & Bullara, D. T. (1993). A dropout prevention program for at-risk high school students: Emphasizing consulting to promote positive classroom climates. *Education and Treatment of Children*, 16, 135-146.

McKee, E. E. (1994). *Using edible reinforcement to decrease the number of inappropriate verbalizations of a first grade student.* Unpublished manuscript, Johns Hopkins University, Rockville, MD.

Prater, M. A., Hogan, S., & Miller, S. R. (1992). Using self-monitoring to improve on-task behavior and academic skills of an adolescent with mild handicaps across special and regular education settings. *Education and Treatment of Children, 15*, 43-55.

Reimers, T. M., Wacker, D. P., & Koeppl, G. (1987). Acceptability of behavioral interventions: A review of the literature. *School Psychology Review*, 16, 212-227.

Reitz, A. L. (1994). Implementing comprehensive classroom-based programs for students with emotional and behavioral problems. *Education and Treatment of Children*, 17, 312-331.

Smith, D. D., & Rivera, D. P. (1995). Discipline in special education and general education settings. *Focus on Exceptional Children*, 27(5), 1-14.

Excerpt:

Special Web Focus

How to Manage Disruptive Behavior in Inclusive Classrooms

Special Focus on Discipline Home

Journals, Books, and Media

CEC Home Page

Due Process in Discipline

In the movement toward inclusive classrooms (and inclusion schools), general education classrooms have included an increasing number of students with mild disabilities (e.g., emotional/behavioral disorders, learning disabilities, mild mental disabilities) (U.S. Department of Education, 1996). The guiding principle of this movement is the provision of equitable educational opportunities for all students, including those with severe disabilities, with needed supplementary aids and support services, in age-appropriate general education classes in their neighborhood schools (National Center on Educational Restructuring and Inclusion, 1994). Educators, researchers, and policymakers are beginning to examine educational practices and outcomes for students both with and without disabilities in inclusion classrooms. Researchers and others are looking at four factors:

- The ability of classroom teachers to provide instruction to students with disabilities in general classroom settings.
- The academic, behavioral, and social outcomes for students with and without disabilities.
- Legal ramifications that may result from inappropriate instructional and management practices.
- Litigation and case law resulting from the use of disciplinary practices such as suspension, expulsion, and time-out.

Vera I. Daniels

Maintaining appropriate classroom behavior can be a complex and difficult task. This task becomes more stressful when it involves students with disabilities. When students with disabilities display disruptive behavior, classroom teachers must carefully and methodically think about the discipline strategies they might employ. Although the disruptive behavior some of these students exhibit is similar to that of students without disabilities, the discipline strategies used to correct or redirect disruptive behavior can vary considerably (see box, "Due Process"). This article provides classroom teachers in inclusion settings with suggestions for addressing behavioral infractions of students with disabilities. In using these strategies, teachers and other practitioners should develop skills in diagnostic, reflective thinking and in making choices among strategies.

The Same or Different Disciplinary Strategies?

Generally, classroom teachers can use the same disciplinary practices to manage the disruptive behavior of students with disabilities that they use to manage the behavior of students without disabilities. Much of the undesirable behavior exhibited by both groups is similar in nature. The differences, however, may originate in the teacher's selection of the particular behavioral intervention. • • •

BEST COPY AVAILABLE

The Individuals with Disabilities Education Act Amendments (IDEA, 1997, formerly known as the Education for All Handicapped Children Act, Public Law 94-142) encourages the inclusion of children with disabilities in the least restrictive environment (LRE) to the maximum extent appropriate with children who are not disabled. Specifically, this act states: Special classes, separate schooling or other removal of children with disabilities from the regular educational environment occurs only when the nature or severity of the disability of a child is such that education in regular classes with the use of supplementary aids and services cannot be achieved satisfactorily. Although the procedural safeguards in IDEA historically provided the foundation for ensuring access to a free and appropriate public education for all children with disabilities in the LRE, these safeguards have not always been clear when it comes to the discipline of students with disabilities. Much of the past controversy concerning the discipline of students with disabilities has focused on the use of corporal punishment, suspension, expulsion, time out, and case law resulting from the use of these procedures (Katsiyannis, 1995; Sorenson, 1990; Yell, 1990). The passage of the IDEA Amendments of 1997, however, should significantly lessen much of the future controversy and court litigation on disciplinary practices of students with disabilities. The due process procedures in the IDEA

- Retain the "stay-put" provision.
- Add clarification to the procedural safeguard provisions to facilitate conflict resolution.
- Describe how schools may discipline children with disabilities, including those who affect the school safety of peers, teachers, and themselves.
- Provide comprehensive guidelines on the matter of disciplining children with disabilities so that both educators and administrators will have a better understanding of their areas of discretion in disciplining student with disabilities. Finally, in cases where the child's behavior is not a manifestation of the disability, IDEA permits a public agency to apply the same disciplinary procedures that would ordinarily apply to children without disabilities.

Here are 10 questions that may help you diagnostically analyze situations that foster disruptive behavior in students with disabilities. These discussions may provide guidance as you select behavior-reduction strategies.

Question 1. Could this misbehavior be a result of inappropriate curriculum or teaching strategies?

Inappropriate curriculum and teaching strategies can contribute to student misbehavior--but not all misbehavior is attributable to these factors. Some misbehavior may arise as a function of the teacher's inability to meet the diverse needs of all students. Consider these factors:

- Group size.
- Group composition.
- Limited planning time.
- Cultural and linguistic barriers.
- Lack of access to equipment, materials, and resources.

If the misbehavior evolves as a result of inappropriate curriculum or teaching strategies, redress the content and skill level components of your curriculum, its futuristic benefit for the student, and the formats you use in instructional delivery. When you identify the instructional needs of students within the context of the classroom, using a diagnostic prescriptive approach, and make curricular adaptations both in content and instructional delivery, you can greatly reduce the occurrence of student misbehavior.

BEST COPY AVAILABLE

Positive Feedback

Madsen and Madsen (1983) emphasized the following ways that teachers can give positive feedback to students to encourage desirable behavior in the classroom: -Words (spoken-written: wonderful, excellent, absolutely right, fantastic, terrific, marvelous, splendid, all right, clever, thank you, that's good work, well thought out, that shows a great deal of work, I agree, keep working hard, you've improved).

- Physical expressions (facial-bodily: smiling, nodding, signaling OK, thumbs up, shaking head).
- Closeness (nearness-touching: interacting with class at recess, sitting on desk near students, walking among students, patting shoulder, touching hand).
- Activities (individual-social: leading student groups, running errands, putting away materials, choosing activities, leading discussions, movies, playing records, visiting another class, making a game of subject matter, presenting skits).
- Things (materials, food, playthings, awards, e.g., games, book markers, stapler, bulletin board, puzzles, popcorn, ice cream, cookies, candy bars, medals, plaques, citations).

Special Focus on Discipline Home

Journals, Books, and Media

CEC Home Page

Question 2. Could this misbehavior be a result of the student's inability to understand the concepts being taught?

When there is a mismatch between teaching style and the learning styles of students, misbehavior inevitably results. Incidents of misbehavior may also result when students refuse to learn concepts because they are unable to see the relationship between the skills being taught and how these skills transcend to the context of the larger environment. In these situations, you should employ strategies and tactics that show students how component skills have meaning in the classroom and in the community. . . .

Question 3. Could this misbehavior be an underlying result of the student's disability?

Some disruptive behavior may be a result of the student's disability (e.g., emotional/behavioral disorders). Meanwhile, other behavior may result from deliberate actions taken by the student to cause classroom disruption. Determining the underlying cause of a student's disruptive behavior involves a careful analysis of the behavior, as follows:

- Try to clarify what kinds of behavior are causing concern.
- Specify what is wrong with that behavior.
- Decide what action should be taken to address the behavior. -Specify what behavior you desire from the student.
- Implement a plan to correct conditions, variables, or circumstances that contribute to the problem behavior (Charles, 1996). . . .

BEST COPY AVAILABLE

Question 4. Could this misbehavior be a result of other factors?

Many aspects of classroom life may contribute to students' misbehavior: the physical arrangement of the classroom, boredom or frustration, transitional periods, lack of awareness of what is going on in every area of the classroom. Remember, however, that classroom climate and physical arrangements can also encourage desirable behavior. You should regularly assess your teaching and learning environment for conditions or procedures that perpetuate or encourage misbehavior. Because inappropriate behavioral manifestations of students can also stem from certain types of teaching behavior, teachers need to become more cognizant of the kinds of behavior they emit and the relationship between their teaching behavior and the resultant behavior of students. Examine your instruction and interactions with students in ongoing classroom life, as follows:

- The development of relevant, interesting, and appropriate curriculums.
- The manner in which you give recognition and understanding of each student as an individual with his or her unique set of characteristics and needs.
- Your own behavior as a teacher, and characteristics such as those identified by Kounin (1970)--withitness, overlapping--that reduce misbehavior, increase instructional time, and maintain group focus and movement management of students.

Question 5. Are there causes of misbehavior that I can control?

As a teacher, you can control many variables to thwart undesirable behavior. You may modify or change your curriculum; make adaptations in instruction to address multiple intelligences; and make changes in your communication style, attitude toward students with disabilities, and expectations of these students. Analyze how much positive feedback you give students. . . .

Question 6. How do I determine if the misbehavior is classroom based?

This is a difficult question. Conducting a self-evaluation of teaching style and instructional practices--as in the previous questions--may provide some insight into whether the behavior is related to the disability or is classroom based. You may find a classroom ecological inventory (Fuchs, Fernstrom, Scott, Fuchs, & Vandermeer, 1994) helpful in determining cause-effect relationships of student misbehavior. The classroom ecological inventory could help you assess salient features of the learning environment of your school or classroom. . . .

Question 7. How do I teach students to self-regulate or self-manage behavior?

You can teach students to self-regulate or self-manage their behavior by teaching them to use the skills of self-management:

- Self-instruction, self-recording, or self-monitoring.
- Self-reinforcement, self-evaluation, and self-punishment.
- Multiple-component treatment packages (Carter, 1993; Hughes, Ruhl, & Peterson, 1988; Rosenbaum & Drabman, 1979). . . .

Question 8. How do I determine what methods of control are appropriate without violating the rights of students with disabilities mandated under P.L. 105-17?

Determining which behavior-reduction methods to use with students with disabilities is not as difficult as you may think. As mentioned previously, the behavioral interventions typically used with students without disabilities can also be used with students with disabilities with a few exceptions. . . .

Question 9. How do I use reinforcement strategies to reduce disruptive behavior?

Teachers can use many types of reinforcers to teach desirable behavior. Madsen and Madsen (1983) identified five categories of responses available for teaching desired behavior: the use of words, physical expressions, physical closeness, activities, and things used as rewards or positive feedback . . .

Question 10. Is it appropriate for me to use punishment?

Punishment, the most controversial aversive behavior management procedure, has been used and abused with students with disabilities (Braaten, Simpson, Rosell, & Reilly, 1988). Because of its abuse, the use of punishment as a behavioral change procedure continues to raise a number of concerns regarding legal and ethical ramifications. Although punishment is effective in suppressing unacceptable behavior, it does have some limitations:

- The reduction in disruptive behavior may not be pervasive across all settings.
- The effect may not be persistent over an extended period of time.
- The learner may not acquire skills that replace the disruptive behavior (Schloss, 1987). . . .

Final Thoughts

There is no "one plan fits all" for determining how teachers should respond to the disruptive behavior of students with disabilities in inclusion settings. An initial starting point would include establishing classroom rules, defining classroom limits, setting expectations, clarifying responsibilities, and developing a meaningful and functional curriculum in which all students can receive learning experiences that can be differentiated, individualized, and integrated. . . .

References

Alberto, P. A., & Troutman, A. C. (1995). *Applied behavior analysis for teachers.* (4th ed.). Englewood Cliffs, NJ: Prentice-Hall.*

Ayers, B., & Meyer, L. H. (1992). Helping teachers manage the inclusive classroom: Staff development and teaming star among management strategies. *The School Administrator, 49(2)*, 30-37.

Braaten, S., Simpson, R., Rosell, J., & Reilly, T. (1988). Using punishment with exceptional children: A dilemma for educators. *TEACHING Exceptional Children, 20(2)*, 79-81.

Carpenter, S. L., & McKee-Higgins, E. (1996). Behavior management in inclusive classrooms. *Remedial and Special Education, 17(4)*, 195-203.

Carter, J. F. (1993). Self-management: Education's ultimate goal. *TEACHING Exceptional Children, 25(3)*, 28-32.

Charles, C. M. (1996). Building classroom discipline (5th ed.). New York: Longman.* Cuenin, L. H., & Harris, K. R. (1986). Planning, implementing, and evaluating timeout interventions with exceptional students. *TEACHING Exceptional Children, 18(4)*, 272-276.

Dunlap, L. K., Dunlap, G., Koegel, L. K., & Koegel, R. L. (1991). Using self-monitoring to increase independence. *TEACHING Exceptional Children, 23(3)*, 17-22.

Dunlap, G., Kern, L., dePerczel, M., Clarke, S., Wilson, D., Childs, K. E., White, R., & Falk, G. D. (1993). Functional analysis of classroom variables for students with emotional and behavioral disorders. *Behavioral Disorders, 18(4)*, 275-291.

Evans, S. S., Evans, W. H., & Gable, R. A. (1989). An ecological survey of student behavior. *TEACHING Exceptional Children, 21(4)*, 12-15.

Frith, G. H., & Armstrong, S. W. (1986). Self-monitoring for behavior disordered students. *TEACHING Exceptional Children, 18(2),* 144-148.

Foster-Johnson, L., & Dunlap, G. (1993). Using functional assessment to develop effective individualized interventions for challenging behaviors. *TEACHING Exceptional Children, 25(3)*, 44-50.

Fuchs, D., Fernstrom, P., Scott, S., Fuchs, L., & Vandermeer, L. (1994). Classroom ecological inventory: A process for mainstreaming. *TEACHING Exceptional Children, 26(3),* 11-15.

Hughes, C. A., Ruhl, K. L., & Peterson, S. K. (1988). Teaching self-management skills. *TEACHING Exceptional Children, 20(2),* 70-72.

Katsiyannis, A. (1995). Disciplining students with disabilities: What principals should know. *NASSP Bulletin, 79(575)*, 92-96.

Kounin, J. S. (1970). *Discipline and group management in classrooms.* New York: Holt, Rinehart & Winston.*

Larrivee, B. (1992). *Strategies for effective classroom management: Creating a collaborative climate* (Leader's Guide to Facilitate Learning Experiences). Boston: Allyn & Bacon.*

Madsen, C. H., Jr., & Madsen C. K. (1983). *Teaching/discipline: A positive approach for educational development* (3rd ed.). Raleigh, NC: Contemporary Publishing Company.*

McCarl, J. J., Svobodny, L., & Beare, P. L. (1991). Self-recording in a classroom for students with mild to moderate mental handicaps: Effects on productivity and on-task behavior. *Education and Training in Mental Retardation, 26(1),* 79-88.

Meyer, L. H., & Henry, L. A. (1993). Cooperative classroom management: Student needs and fairness in the regular classroom. In J. Putnam (Ed.), *Cooperative learning and strategies for inclusion: Celebrating diversity in the classroom* (pp. 93-121). Baltimore: Paul H. Brookes.

Moyer, J. R., & Dardig, J. C. (1978). Practical task analysis for special educators. *Teaching Exceptional Children, 11(1),* 16-18.

Murdick, N. L., & Petch-Hogan, B. (1996). Inclusive classroom management: Using preintervention strategies, *Intervention in School and Clinic, 13(3),* 172-196. National Center on Educational Restructuring and Inclusion. (1994). National study of inclusive education. New York: Author. (ERIC Document Reproduction Service No. ED 375 606)

Nelson, J. R., Smith, D. J., Young, R. K., & Dodd, J. M. (1991). A review of self-management outcome research conducted with students who exhibit behavioral disorders. *Behavioral Disorders, 16(13)*, 169-179.

Prater, M. E., Joy, R., Chilman, B., Temple, J., & Miller, S. R. (1991). Self-monitoring of on-task behavior by adolescents with learning disabilities. *Learning Disability Quarterly, 14(13)*, 164-177.

Rosenbaum, M. S., & Drabman, R. S. (1979). Self-control training in the classroom: A review and critique. *Journal of Applied Behavior Analysis, 12(3)*, 467-485.

Schloss, P. J. (1987). Self-management strategies for adolescents entering the work force. *TEACHING Exceptional Children, 19(4)*, 39-43.*

Schloss, P. J., & Smith, M. A. (1994).

Applied behavior analysis in the classroom. Boston: Allyn & Bacon.

Sorenson, G. P. (1990). Special education discipline in the 1990s. *West's Educational Law Reporter, 62(2)*, 387-398.

U.S. Department of Education. (1996). *18th annual report to Congress on the implementation of the Individuals with Disabilities Education Act.* Washington, DC: Office of Special Education. (ERIC Document Reproduction Service No. ED 400 673)

Yell, M. L. (1990). The use of corporal punishment, suspension, expulsion, and timeout with behaviorally disordered students in public schools: Legal considerations. *Behavioral Disorders, 15(2)*, 100-109.

Yell, M. L., & Shriner, J. G. (1997). The IDEA Amendments of 1997: Implications for special and general education teachers, administrators, and teacher trainers. *Focus on Exceptional Children, 30(1)*, 1-19.

*To order books marked by an asterisk (*), please call 24 hrs/365 days: 1-800-BOOKS-NOW (266-5766) or (702) 258-3338; ask for ext. 1212. Use Visa, M/C, or AMEX or send check or money order + $4.95 S&H ($2.50 each add'l item) to: Books Now, 660 W. Charleston Blvd., Las Vegas, NV 89102.

Vera I. Daniels (CEC Chapter #386), Professor, Institute for the Study and Rehabilitation of Exceptional Children and Youth, and Department of Special Education, Southern University and A&M College, Baton Rouge, Louisiana.

Address correspondence to the author at P.O. Box 9523, Baton Rouge, LA 70813 (e-mail: vdaniels@premier.net). Special thanks is extended to the teacher and students appearing in the photographs and to the school principal.

Special Focus on Discipline Home | Journals, Books, and Media | CEC Home Page

copyright © 1998
The Council for Exceptional Children
Last updated: March 2, 1998
Send inquiries/comments to Internet Coordinator
URL: http://www.cec.sped.org

C. EMPIRICALLY SUPPORTED TREATMENTS

In an effort to improve the quality of treatment, the mental health field is promoting the use of empirically supported interventions. The following pages contain *excerpts* from a 1998 report entitled "Effective Psychosocial Treatments; of Conduct-Disordered Children and Adolescents: 29 Years, 82 Studies, and 5,272 Kids" by E. V. Brestan and S. M. Eyberg, which appears in the *Journal of Clinical Child Psychology*, *27*, 180-189.

Excerpted here are the abstract, an adapted table categorizing relevant research, the authors' conclusions, and the authors' reference list.

Abstract of artilce by E. V. Brestan and S. M. Eyberg, which appears in the *Journal of Clinical Child Psychology*, *27*, 180-189.

Reviews psychosocial interventions for child and adolescent conduct problems, including oppositional defiant disorder and conduct disorder, to identify empirically supported treatments. Eighty-two controlled research studies were evaluated using the criteria developed by the Division 12 (Clinical Psychology) Task Force on Promotion and Dissemination of Psychological Procedures. The 82 studies were also examined for specific participant, treatment, and methodological characteristics to describe the treatment literature for child and adolescent conduct problems. Two interventions were identified that met the stringent criteria for well-established treatments: videotape modeling parent training program (Spaccarelli, Cotter, & Penman, 1992; Webster-Stratton, 1984, 1994) and parent-training programs based on Patterson and Gullion 's (1968) manual Living With Children *(Alexander & Parsons, 1973; Bernal, Klinnert, & Schultz, 1980; Wiltz & Patterson, 1974). Twenty of the 82 studies were identified as supporting the efficacy of probably efficacious treatments.*

The excerpts on the following pages highlight the gist of this work.

BEST COPY AVAILABLE

Treatments Identified as Well Established

Two treatments designed for children with conduct problem behaviors were found to have the strong empirical support required of treatments judged to be well established according to the Chambless criteria. These treatments each address the full constellation of behaviors that characterize conduct-disordered children and, collectively, provide new and current standards of care across the developmental spectrum of childhood. Each of these treatments has several supporting studies among which there are studies sufficient to support the well-established treatment criteria and no studies we found that provide disconfirming data. Studies of these treatments demonstrated superiority to psychological placebo or another treatment.

Parent Training Based on Living With Children

Parent-training programs based on Patterson and Gullion's (1968) manual *Living With Children* are based on operant principles of behavior change and designed to teach parents to monitor targeted deviant behaviors, monitor and reward incompatible behaviors, and ignore or punish deviant behaviors of their child. The treatment has been found superior to control groups in several controlled studies including Alexander and Parsons (1973): Bernal, Klinnert, and Schultz (1980); Firestone, Kelly, and Fike (1980); and Wiltz and Patterson (1974). Treatments using the lessons from *Living With Children* have generally been short-term behavioral parent-training programs and have been compared to standard treatments for children with conduct problems (e.g., psychodynamic therapy, client-centered therapy) in addition to no-treatment control groups. ...

Videotape Modeling Parent Training

Webster-Stratton's parent-training program includes a videotape series of parent-training lessons and is based on principles of parent training originally described by Hanf (1969). Videotape modeling parent training is intended to be administered to parents in groups with therapist-led group discussion of the videotape lessons. The treatment has been tested in several studies, including Spaccarelli, Cotler, and Penman (1992); Webster-Stratton (1984, 1990, 1994); and Webster-Stratton, Kolpacoff, and Hollinsworth (1988), in which it has been compared to wait-list control groups and to alternative parent-training formats. The studies have typically included both boys and girls in the 4- to 8-year-old age range who have been selected for treatment based on either parent referral for behavior problems or diagnostic criteria for ODD or CD.

Parents receiving videotape modeling parent training have rated their children as having fewer problems after treatment than control parents, and these parents have rated themselves as having better attitudes toward their child and greater self-confidence regarding their parenting role. Parents receiving the videotape treatment have also shown better parenting skills than control parents on observational measures in the home, and their children have shown greater reduction in observed deviant behavior.

Treatments Identified as Probably Efficacious

Ten treatments for children or adolescents with conduct problem behaviors were found to have the necessary empirical support required of treatments judged probably efficacious according to the Chambless criteria. These treatments and their supporting studies are listed in Table 2. Among the studies meeting the probably efficacious treatment criteria, there is strong representation of parent-child treatments based on Hanf's (1969) two-stage behavioral treatment model for preschool-age children (Eyberg, Boggs, & Algina, 1995; Hamilton & MacQuiddy, 1984; McNeil, Eyberg, Eisenstadt, Newcomb, & Funderburk, 1991; Peed, Roberts, & Forehand, 1977; Wells & Egan, 1988; Zangwill, 1983), as is Webster-Stratton's well-established treatment using videotape modeling. The delinquency prevention program (Tremblay, Pagani-Kurtz, Masse, Vitaro, & Phil, 1995; Vitaro & Tremblay, 1994) is also designed for preschool-age children.

Treatments for older children with conduct problem behaviors are represented in the probably efficacious treatments as well. Research teams led by Kazdin, studying problem solving skills training (Kazdin, Esveldt-Dawson, French, & Unis, 1987a, 1987b; Kazdin, Siegel, & Bass, 1992), and by Lochman, studying anger coping therapy (Lochman, Burch, Curry, & Lampron, 1984; Lochman, Lampron, Gemmer, & Harris, 1989) have each conducted rigorous evaluations of treatments for school-age children (see Table 2). Finally, four treatments for conduct-disordered adolescents have attained probably efficacious treatment status: anger control/stress inoculation (Feindler, Marriott, & Iwata, 1984; Schlichter & Horan, 1981) assertiveness training (Huey & Rank, 1984), multisystemic therapy (Borduin et al., 1995; Henggeler, Melton, & Smith, 1992; Henggeler et al., 1986), and rational-emotive therapy (Block, 1978).

Table 2. The Probably Efficacious Treatments and the Studies Supporting Their Efficacy

Treatment	**Supporting Studies**
Anger Control Training With Stress Inoculation	Feindler, Marriott, & Iwata (1984); Schlichter & Horan (1981)
Anger Coping Therapy	Lochman, Burch, Curry, & Lampron (1984); Lochman, Lampron, Gemmer, & Harris (1989)
Assertiveness Training	Huey & Rank (1984)
Delinquency Prevention Program	Tremblay, Pagani-Kunz, Masse, Vitaro, & Phil (1995); Vitaro & Tremblay (1994)
Multisystemic Therapy	Borduin, Mann, Cone, Henggeler, Fucci, Blaskse, & Williams (1995); Henggeler, Rodick, Borduin, Hanson, Watson, & Urey (1986); Henggeler, Melton, & Smith (1992)
Parent-Child Interaction Therapy	Eyberg, Boggs, & Algina (1995); McNeil, Eyberg, Eisenstadt, Newcomb, & Funderburk (1991); Zangwill (1983)
Parent Training Program	Peed, Roberts, & Forehand (1977); Wells & Egan (1988)
Problem Solving Skills Training	Kazdin, Esveldt-Dawson, French, & Unis (1987a); Kazdin, Esveldt-Dawson, French, & Unis (1987b); Kazdin, Siegel, & Bass (1992)
Rational-Emotive Therapy	Block (1978)
Time-Out Plus Signal Seat Treatment	Hamilton & MacQuiddy (1984)

References

Alexander, J. F., & Parsons, B. V. (1973). Short-term behavioral intervention with delinquent families: Impact on family process and recidivism. Journal of Abnormal Psychology, 81, 219-225.

American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders* (3rd ed. rev.). Washington, DC: Author.

American Psychiatric Association. *(1994) Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

Bernal, M. E., Klinnert, M. D., & Schultz, L. A. (1980). Outcome evaluation of behavioral parent training and client-centered parent counseling for children with conduct problems. *Journal of Applied Behavior Analysis, 13*, 677-691.

Block, J. (1978). Effects of a rational-emotive mental health program on poorly achieving disruptive high school students. *Journal of Counseling Psychology, 25*, 61-65.

Borduin, C. M., Mann, B. J., Cone, L. T., Henggeler, S. W., Fucci, B. R., Blaske, D. M., & Williams, R. A. (1995). Multisystemic treatment of serious juvenile offenders: Long-term prevention of criminality and violence. *Journal of Consulting and Clinical Psychology, 63*, 569-578.

Chambless, D. L., & Hollon, S. D. (in press). Defining empirically supported therapies. *Journal of Consulting and Clinical Psychology.*

Chambless, D. L, Sanderson, W. C., Shoham, V., Bennett Johnson, S., Pope, K. S., Crits-Cristoph, P., Baker, M., Johnson, B., Woody, S. R., Sue, S., Beutler, L., Williams, D. A., & McCurry, S. (1996). An update on empirically validated therapies. *The Clinical Psychologist, 49*, 918.

Dishion, T. J., & Patterson, G. R. (1992). Age effects in parent training outcome. *Behavior Therapy, 23*, 719-729.

Dumas, J. E., (1989). Treating antisocial behavior in children: Child and family approaches. *Clinical Psychology Review, 9*, 197-222.

Durlak, J. A., Fuhrman, T., & Lampman, C. (1991). Effectiveness of cognitive-behavior therapy for maladapting children: A meta-analysis. *Psychological Bulletin, 110*, 206-214.

Eyberg, S. M., Boggs, S., & Algina, J. (1995). Parent-child interaction therapy: A psychosocial model for the treatment of young children with conduct problem behavior and their families. *Psychopharmacology Bulletin, 31*, 83-91.

Eyberg, S. M., Edwards, D. L., Boggs, S. R. & Foote, R. (in press) Maintaining the treatment effects of parent training: The role of booster sessions and other maintenance strategies. *Clinical Psychology: Science and Practice.*

Eyberg, S.M., Schuhmann, E., & Rey, J. (1998). Psychosocial treatment research with children and adolescents: Developmental issues. *Journal of Abnormal Child Psychiatry, 26*, 71-81.

Feindler, D. L., Marriott, S. A. A., & Iwata, M. (1984). Group anger control training for junior high school delinquents. *Cognitive Therapy and Research, 8*, 299-311.

Firestone, P., Kelly, M . J., & Fake, S (1980). Are fathers necessary in parent training groups? *Iournal of Clinical Child Psychology, 9*, 44-47.

Guevremont, D. C., & Foster, S. L. (1993). Impact of social problem-solving training on aggressive boys: Skill

BEST COPY AVAILABLE

acquisition, behavior change, and generalization. *Journal of Abnormal Child Psychology, 27,* 13-27.

Hamilton, S. B., & MacQuiddy, S. L. (1984). Self-administered behavioral parent training: Enhancement of treatment efficacy using a time-out signal seat. *Journal of Clinical Child Psychology, 13,* 61-69.

Hanf, C. (1969, April). *A two stage program for modifying maternal controlling during the mother-child interaction.* Paper presented at the meeting of the Western Psychological Association, Vancouver, British Columbia, Canada.

Kazdin, A. E. (1986). Comparative outcome studies of psychotherapy: Methodological issues and strategies. *Journal of Consulting and Clinical Psychology, 54,* 95-105.

Kazdin, A. E. (1997). A model for developing effective treatments: Progression and interplay of theory, research, and practice. *Journal of Clinical Child Psychology, 26,* 114- 129.

Kazdin, A. E., & Bass, D. (1989). Power to detect differences between alternative treatments in comparative psychotherapy outcome research. *Journal of Consulting and Clinical Psychology 57,* 138-147.

Kazdin, A. E., Bass, D., Ayres, W. A ., & Rodgers, A. (1990). Empirical and clinical focus of child and adolescent psychotherapy research. *Journal of Consulting and Clinical Psychology, 58* 729-740.

Kazdin, A. E., Esveldt-Dawson, K., French, N. H., & Unis, A. S. (1987a). Effects of parent management training and problem-solving skills training combined in the treatment of antisocial child behavior. *Journal* of *the American Academy of Child and Adolescent Psychiatry 26,* 416-424.

Kazdin, A. E., Esveldt-Dawson, K., French, N. H., & Unis, A. S. (1987b). Problem-solving skills training and relationship therapy in the treatment of antisocial child behavior. *Journal of Counseling and Clinical Psychology, 55,* 76-85.

Kazdin, A. E., Siegel, T. C., & Bass, D. (1992). Cognitive problem- solving skills training and parent management training in the treatment of antisocial behavior in children. *Journal of Consulting and Clinical Psychology, 60,* 733-747.

Lochman, J. E., Burch, P. R., Curry, J. F., & Lampron, L. B. (1984). Treatment and generalization effects of cognitive-behavioral and goal-setting interventions with aggressive boys. *Journal of Consulting and Clinical Psychology, 52,* 915-916.

Lochman, J. E., Lampron, L. B., Gemmer or, T. C., & Harris, S. R. (1989). Teacher consultation and cognitive-behavioral interventions with aggressive boys. *Psychology in the School, 26,* 179-188.

McMahon, R. J., & Wells, K. C. (1989). Conduct disorders. In E.J. Mash & R. A. Barkley (Eds.), *Treatment of childhood disorders* (pp. 73-132). New York: Guilford.

McNeil, C. B., Eyberg, S., Eisenstadt, T. H., Newcomb, K., & Funderburk, B . W. (1991). Parent-child interaction therapy with behavior problem children: Generalization of treatment effects to the school setting. *Journal of Clinical Child Psychology, 20,* 140- 151.

Patterson, G. R., & Gullion, M. E. (1968). *Living with children: New methods for parents and teacher.* Champaign, IL: Research Press.

Peed, S., Roberts, M., & Forehand, R. (1977). Evaluation of the effectiveness of a standardized parent training program in altering the interaction of mothers and their noncompliant children. *Behavior Modification, 1,* 323-350.

Prinz, R.J., & Miller, G. B. (1994). Family-based treatment for childhood antisocial behavior. Experimental influences on dropout and engagement. *Journal of Consulting and Clinical Psychology, 62,* 645-650.

Ruma, P. R., Burke, R. V., & Thompson, R. W. (1996). Group parent training: is it effective for children of all ages? *Behavior Therapy, 27,* 159-169.

Sattler, J. M. (1992). *Assessment of children: Revised and updated third edition.* San Diego: Sattler.

Schlichter, K. J., & [illegible]oran, J. J. (1981). Effects of stress inoculation on the anger and aggression management skills of institutionalized juvenile delinquents. *Cognitive Therapy and Research, 5,* 359-365.

Schuhmann, E, Durning, P.,Eyberg, S., & Boggs, S. (1996). Screening for conduct problem behavior in pediatric settings using the Eyberg Child Behavior Inventory. *Ambulatory Child Health, 2,* 35-41.

Serketich, W.J., & Dumas, J. E. (1996). The effectiveness of behavioral parent training to modify antisocial behavior in children: A meta-analysis. *Behavior Therapy, 27,* 171-186.

Spaccarelli, S., Cotler S., & Penman, D. (1992). Problem-solving skills training as a supplement to behavioral parent training. *Cognitive Therapy and Research, 16,* 1-18.

Sue, D. W. (1990). Culture-specific strategies in counseling: A conceptual framework. *Professional Psychology: Research and Practice, 21,* 424 433.

Task Force on Promotion and Dissemination of Psychological Procedures. (1995). Training in and dissemination of empirically-validated psychological treatments: Report and recommendations. *The Clinical Psychologist, 48,* 3-23.

Tremblay, R. E., Pagani-Kurtz, L., Masse, L. C., Vitaro, F., & Phil, R. (1995). A bimodal preventive intervention for disruptive kindergarten boys: Its impact through mid-adolescence. *Journal of Consulting and Clinical Psychology, 63,* 560-568.

Vitaro, F., & Tremblay, R. E. (1994). Impact of a prevention program on aggressive children's friendships and social adjustment. *Journal of Abnormal Child Psychology, 22,* 457-475.

Webster-Stratton, C. (1984). Randomized trial of two parent-training programs for families with conduct-disordered children. *Journal of Consulting and Clinical Psychology,* 52, 666-678.

Webster-Stratton, C. (1990). Enhancing the effectiveness of self-administered videotape parent training for families with conduct-problem children. *Journal of Abnormal Child Psychology,* 18, 479-492.

Webster-Stratton C. (1994). Advancing videotape parent training: A comparison study. *Journal of Consulting and Clinical*

Psychology, 62, 583-593.

Webster-Stratton, C., Kolpacoff, M., & Hollinsworth, T. (1988). Self-administered videotape therapy for families with conduct-problem children: Comparison with two cost effective treatments and a control group. *Journal of Consulting and Clinical Psychology, 56*, 558-566.

Weisz, J. R., Weiss, B., Alicke, M. D., & Klotz, M. L. (1987). Effectiveness of psychotherapy with children and adolescents: A meta-analysis for clinicians. *Journal of Consulting and Clinical Psychology, 56*, 542-549.

Weisz, J. R., Weiss, B., Han, S. S., Granger, D. A., & Morton, T. (1995). Effects of psychotherapy with children and adolescents revisited: A meta-analysis of treatment outcome studies. *Psychological Bulletin, 117*, 450-468.

Wells, K. C., & Egan, J. (1988). Social learning and systems family therapy for childhood oppositional disorder. Comparative treatment outcome. *Comprehensive Psychiatry, 29*, 138-146.

Wiltz, N. A., & Patterson, G. R. (1974). An evaluation of parent training procedures designed to alter inappropriate aggressive behavior of boys. *Behavior Therapy, 5*, 215-221.

Zangwill, W. M. (1983) An evaluation of a parent training program. *Child & Family Behavior Therapy, 5*, 1-6.

BEST COPY AVAILABLE

D. PSYCHOTROPIC MEDICATIONS

This chart provides some brief information on psychotropic medications frequently prescribed for students. The medications are listed with respect to the diagnosis that leads to their prescription. For more information, see the *Physicians Desk Reference.*

Diagnosis: Conduct Disorder – Medication Types and Treatment Effects
(There continues to be controversy over whether medication is indicated for this diagnosis. However, because it is prescribed widely for such cases, it is included here.)

A. *Anti-psychotics*

Used to treat severe behavioral problems in children marked by combativeness and/or explosive hyperexcitable behavior (out of proportion to immediate provocations). Also used in short-term treatment of children diagnosed with conduct disorders who show excessive motor activity impulsivity, difficulty sustaining attention, aggressiveness, mood lability and poor frustration tolerance.

B. Anti-manic

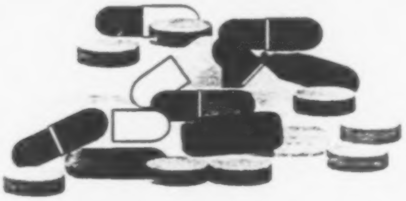
Used to reduce the frequency and intensity of manic episodes. Typical symptoms of mania include pressure of speech, motor hyperactivity, reduced need for sleep, flight of ideas, grandiosity, or poor judgement, aggressiveness, and possible hostility.

C. Beta-adenergic antagonists

Although primarily used in controlling hypertension and cardiac problems, beta-adenergic antagonists such as propranolol hydrochloride are used to reduce somatic symptoms of anxiety such as palpitations, tremulousness, perspiration, and blushing. In some studies, propranolol is reported as reducing uncontrolled rage outbursts and/or aggressiveness among children and adolescents (Green, 1995).

*Because many side effects are not predictable, all psychotropic medication requires careful, ongoing monitoring of psychological and physical conditions. Pulse, blood pressure, and signs of allergic reactions need to be monitored frequently, and when medication is taken for prolonged periods, periodic testing of hematological, renal, hepatic, and cardiac functions are essential. Prior to any other physical treatment (surgery, dentistry, etc.), it is important to inform physicians/dentists that psychotropic medication is being taken. Finally, common side effects of many medications are drowsiness/insomnia and related factors that can interfere with effective school performance.

BEST COPY AVAILABLE



Names: Generic (Commercial)	Some Side Effects and Related Considerations
A. Anti-psychotics	
thioridazine hydrochloride [Mellaril. Mellaril-S] chlorpromazine hydrochloride [Thorazine; Thor-Pram]	May manifest sedation, drowsiness, dizziness, fatigue, weight gain, blurred vision, rash, dermatitis, extrapyramidal syndrome (e.g . pseudo-Parkinson. Tardive dyskinesia, hyperactivity), respiratory distress, constipation, photosensitivity. Medication is to be taken with food or a full glass of water or milk. Care to avoid contact with skin because of the danger of contact dermatitis. Gradual discontinuation is recommended. Drowsiness can be reduced with decreased dosages. Youngster is to move slowly from sitting or lying down positions. Care must be taken to minimize exposure to strong sun.
haloperidol [Haldol]	May manifest insomnia, restlessness, fatigue, weight gain, dry mouth, constipation,extrapyamidal reactions (e.g., pseudo-Parkinson, Tardive dyskinesia, dystonia, muscle spasms in neck and back, trembling hands), blurred vision, photosensitivity, decreased sweating leading to overheating. menstrual irreg. Avoid sun and overheating. Discontinue gradually.
B. Anti-manic	
lithium carbonate/citrate [Lithium. Lithane, Lithobid. Lithotabs, Lithonate, Eskalith Cibalith]	Safety and effectiveness have not been established for those under 15 years of age. May manifest tremor, drowsiness, dizziness, nausea, vomiting, fatigue, irritability, clumsiness, slurred speech, diarrhea, increased thirst, excessive weight gain, acne, rash. Serum levels must be monitored carefully because of therapeutic dose is close to toxic level. Care must be taken to maintain normal fluid and salt levels
propranolol hydrochloride [Inderal]	May manifest sleep disturbance, drowsiness, confusion, depression, light headedness, nausea, vomiting, fatigue, dry mouth, heartburn, weight gain, leg fatigue. Administer before meals and bed. Avoid having extremities exposed to cold for long periods. Discontinue gradually over a two week period.

Revisiting Medication for Kids

Psychiatrist Glen Pearson is president of the American Society for Adolescent Psychiatry (ASAP). The following is republished with his permission from the society's newsletter.

It happens several times a week in my practice of community child and adolescent psychiatry: Our society's overwhelming belief in medically controlling our kids' behavior finds expression in ever more Huxleyesque demands on the psychiatrist to prescribe. This week's winners are the school district, the juvenile court, and a religious shelter for homeless families with children. Their respective would-be victims are LaShondra, Trevor, and Jimmy.

Jimmy is a 9 year old boy with a long history of treatment for severe emotional disturbance. He's in a school-based day treatment program and seems to be making terrific progress on self-managing his behavior. This turnaround has occurred just in the past few weeks, following an acute psychiatric hospital stay during which the many psychotropic medications he'd been taking without apparent benefit were tapered and discontinued. He was discharged to the day treatment facility and is receiving case management and therapeutic services at home in the community. Unfortunately, the grandmother with whom he lives has been evicted from her residence, and has applied for assistance to a homeless family program. She and Jimmy are scheduled to be admitted to a shelter program next week, but the shelter has made it a condition of receiving services that Jimmy be on medication

LaShondra is 14. She is in special education classes at her junior high school because of mild mental retardation and emotional disturbance. She bears both physical and psychic scars of early prolonged abuse, and has symptoms of borderline personality pathology and PTSD. She likes school and wants to learn, but keeps getting expelled for behavioral outbursts. The school, too, has made it a condition of her readmittance to classes that she be on medication. LaShondra experiences psychotropic medication as inimical to her emerging adolescent autonomy, and has had negative therapeutic effects during past trials of treatment.

Trevor, at 15, is incarcerated in the Juvenile Detention Center, awaiting a hearing on certification to stand trial as an adult on two charges of capital murder. We have evaluated him for fitness to proceed and determined that he's not mentally ill, but are involved in providing services to Trevor in consultation with the juvenile authorities because he is persistently threatening suicide. We think the best plan is to keep him closely supervised in detention, but the juvenile department is concerned about their liability and petition the court to transfer him to a psychiatric hospital. Two hearings are held on the same day. At the first hearing Trevor is committed to a private facility, on condition that the facility accepts the admission. The facility refuses. At the second hearing, Trevor is committed to the state hospital on condition that the hospital certifies that they can guarantee security.

The hospital can't. The Court then orders that Trevor be involuntarily administered unspecified psychotropic agents by injection.

I am not making these things up. These three cases have so far occupied the last three days of my week, and I'm telling you about them not to garner sympathy for the kids (only two of whom have any sympathy coming in any case), or for me (despite my clearly deserving some), but to focus attention on the astonishing degree to which everyone in our society has come to believe in the prescribing of psychotropic medication as a cure, or at least a control, for disturbing behavior in kids. How did we arrive at this state of affairs? Though a very complex interaction among a myriad of scientific, social, and historical factors, of which I want to mention just two of the scientific ones: progress in psychiatric nosology, and progress in biological psychiatry.

Since 1980, we've trained a generation or two of psychiatrists in the phenomenological approach to diagnosis. The last three editions of the DSM (III-R, and IV) are determinedly atheoretical and empirical in their approach (the majority of members of the Work Groups on Child and Adolescent Disorders for the last three DSM's have been pediatric psychopharmacology researchers), and I think we have long since abandoned trying to teach residents to think about the meanings of symptoms to patients (and ourselves), about the dynamics of intrapsychic structure and interpersonal process. During the same time, the explosive growth of neuroscience and pharmacology has given us many new tools with which to work (if only we knew how: my friend and teacher Bob Beavers used to say, "if the only tool you have is a hammer, everything looks like a nail to you!").

In short, I think we've unwittingly relinquished our most powerful and proven tool: appropriately affectionate, professionally respectful, intimate personal engagement of the patient in mutual exploration of inner meanings. We're frittering our therapeutic potency away on serial trials of psychotropic drugs, and we're prescribing for patients when we don't know the person. There are too many kids on too many drugs, and many of the kids have been given medication as a substitute for engagement and exploration of personal issues.

The point I'm trying to make is that every sector of today's society contributes to this pressure to prescribe. Parents believe medication will cure, schools believe it, courts believe it, even nonpsychiatric mental health professionals believe it. Well, I don't believe it, and it's been my experience with ASAP that most of our members don't believe it either. And, if not only do we not believe that medicine cures, but also we do believe that we have a more powerful and effective treatment which provides an essential context for medication to be helpful, let's stand up and say so. I look forward to hearing from y'all: agree or disagree.

V. A Few Resource Aids

A. An Example of One State's Disciplinary Program

B. Fact Sheets

C. A few more Resources from our Center

A. An Example of One State's Disciplinary Program

FLORIDA DEPARTMENT OF EDUCATION

BUREAU OF INSTRUCTIONAL SUPPORT AND COMMUNITY SERVICES

http://sun3.firn.edu/doe/bin00014/notewort.htm

DISCIPLINARY PROGRAMS

PROGRAM TITLE: BAKER COUNTY ALTERNATIVE SCHOOL

DISTRICT: BAKER

The Baker County Alternative School provides an opportunity for 4th through 12th grade students to continue their education in an environment which best meets their needs while insuring the safety and welfare of the general student body. A "second chance" assignment in a highly structured counseling setting provides the incentive and guidance necessary to enable these students to avoid expulsion from school.

This center is designed to limit instances which seriously endanger the safety and security of school personnel and other students. It creates a more positive attitude toward education and the community in the student, increases the graduation rate, and decreases the dropout and non-promotion rate. The program also provides a "second chance" in lieu of expulsions for students who misbehave in other programs or have committed serious infractions of the Student Code of Conduct. The program aims to help students understand the serious consequences of their actions and the need to modify behavior to ensure success at school and in life.

The staff includes two fully certified teachers, one instructional assistant and an on-site administrator. The GED/HSCT Exit Option is available and the program offers performance-based and computer-assisted instruction.

PROGRAM TITLE: THE LEARNING CENTER

DISTRICT: GILCHRIST

The purpose of this program is to provide a learning environment for disruptive students while maintaining their academic progress. The Gilchrist County School System believes that students with a history of disruptive behavior need to be separated from the student body and given individualized instruction and group counseling in behavior management.

The Learning Center program consists of instruction and counseling. Academics, vocational skills, and counseling are all part of the curriculum. Teachers give weekly assignments so that students are completing the same assignments as their peers in regular classes and there is no academic gap upon returning to the regular classroom. Students are placed in the Learning Center for a minimum of six weeks.

PROGRAM TITLE:
TELECLASS/ABEYANCE
DISTRICT: BROWARD

The Teleclass/Abeyance Program is a credit-granting academic program that is designed to use distance learning to meet the needs of 40 middle and high school students whose expulsion has been held in abeyance. These students have gone through the normal expulsion process for possession of weapons or illegal substances, for presenting a threat of physical harm, or for the destruction to property.

The Teleclass/Abeyance Program is voluntary and lasts one calendar year from the date of expulsion. The student and parents sign a contractual agreement that the student will have a 95% attendance rate, will actively participate in class, and will achieve and maintain an agreed-upon grade point average. The student will be responsible for completing 30 community service hours plus complete counseling as part of the contract. Upon successful completion of the program, the student's expulsion record is purged from the file and the transcript shows only a transfer from one school to another. Should the student miss five consecutive days or violate the contract, the student is dismissed from the program.

All students are taught by long distance learning through the telephone. Each student is provided with a speaker phone and the appropriate subject textbooks. The teacher is equipped with an AT&T Quorum console that can accommodate up to twenty students at a time from anywhere in the country. The teacher can hear all of the students at the same time and the students can hear each other as well, just as in a conference call.

Students learn the self-discipline of calling in on time, staying on task and actively participating in class in each subject. Due to the small number per class, individual one-on-one instruction regularly takes place. Homework is assigned and sent in via the internal school mail system by the parents, as well as by modems and fax machines. Teleclass/Abeyance allows the students to obtain credit for the courses taken and to develop social and cognitive skills, abstract and critical thinking skills, and to have adult supervision for six hours per day.

PROGRAM TITLE: CLOVERLEAF ENVIRONMENTAL CENTER
DISTRICT: HIGHLANDS

Cloverleaf Environmental Center serves alternative and exceptional education students from the 6th through 8th grades. It serves students who have been disruptive in the regular school setting, who have been chronically truant, have expulsions held in abeyance by school board action, or have a need for a more restrictive educational environment.

The interdisciplinary curriculum is used in a learning environment that allows students to develop a more complete understanding of complex issues. Environmental science is the common thread in this program, with cooperation between the school board, the University of Florida, 4-H, the Audubon Society, the Game and Freshwater Fish Commission, Wrede's Wildlife Rehabilitation, the Archbold Biological Station, the Florida Trail Association and Highlands Hammock State Park.

The curriculum includes an affective component designed to increase self-esteem, develop social skills, and teach responsibility for one's actions. Academic instruction is enhanced by computer-assisted instruction.

A full-time counselor is provided through Tri-County Addictions, Inc., with group and individual counseling available for each student. Also available to the staff are programs of "I Can - We Can", High and Low Ropes Courses and various lakeside water activities.

The goal for each student is to participate in activities designed around 12 outdoor centers with a culmination of acting as tour guides for other students who visit the center.

PROGRAM TITLE: RIVERVIEW AND EUCLID AVENUE LEARNING CENTERS
DISTRICT: VOLUSIA

Riverview and Euclid Avenue Learning Centers provide disciplinary programs for students in middle and high school. The programs serve students who have a history of adjustment problems in the traditional school, disruptive behavior, or have committed offenses which warrant suspension or expulsion according to the guidelines in the district's code of student conduct. The program consists of a structured environment in which individual plans for behavioral modification and academic instruction are provided. There is close coordination with parents, student services, and outside agencies.

BEST COPY AVAILABLE

PROGRAM TITLE: STUDENT SUPPORT AND ASSISTANCE PROGRAM

DISTRICT: VOLUSIA

This consultative disciplinary program provides services to students in their regular classroom setting. These services include behavior modification, attendance and discipline monitoring, and assist the student in school success. This program provides direct services or benefits to both students and their teachers. There is close coordination with parents, student services, and outside agencies.

PROGRAM TITLE: ALTERNATIVE CHOICES EDUCATIONAL (ACE) SCHOOL

DISTRICT: JACKSON

The Alternative Choices Educational (ACE) School is a cooperative venture of the Jackson County School Board, the district's schools that have grades six through twelve, and other appropriate agencies. The school serves a maximum of thirty students, ages 12 through 18, who are unable to function successfully in a regular school setting due to problems that include disruptive behavior, acting-out, assaultive behavior, substance abuse, possession of weapons on campus, truancy, or activities in or out of school that result in involvement with the criminal justice system. Students who have dropped out of school due to disciplinary problems or were unsuccessful in traditional schools are also retrieved. Based on the superintendent's recommendation and the school board's action, students who have committed expellable offenses may be given the option of attending ACE School in lieu of expulsion from other Jackson County Schools.

ACE School provides an educational and behavioral program that uses individualized performance-based instruction geared to the specific abilities and needs of each student. Individual and/or group counseling is provided, as well as testing and assessment of each student where deemed appropriate.

The behavioral component of the ACE School is designed to provide students with incentives that will facilitate their successful re-entry into a regular public school. The performance component includes computer instruction tailored to each student's academic level. Students in grades 9 through 12 are enrolled in performance-based instruction and are awarded credits toward a standard high school diploma. Students below grade 9, complete units that allow promotion to the next grade level.

ACE School was recently awarded a Learn and Serve Grant. The grant project was entitled "ACE Serving Others". This was an opportunity for all ACE students to help other less fortunate students and to learn critical thinking skills, organizational skills, planning and self-discipline. ACE students served as mentors and assistants in classrooms which serve mentally handicapped and severely emotionally disturbed students. This proved to be a successful venture for the ACE students, as well as the students who received services.

Since the ACE School was implemented in the fall of 1995-96, 14 students have successfully returned to their home schools.

BEST COPY AVAILABLE

PROGRAM TITLE: DAY-TIME OFF-CAMPUS (DTOC) EDUCATION PROGRAM

DISTRICT: NASSAU

The Day-Time Off-Campus (DTOC) Education Program is designed to provide an opportunity for eligible students to continue their education in an environment which best meets their needs, while insuring the safety and welfare of the general student body. The program is designed with the belief that a "second chance" through assignment in a highly structured counseling setting may provide students with the incentive and guidance necessary to avoid expulsion.

> The goal is to provide educational opportunities in an off-campus setting that help students understand the serious consequences of their actions and the need to modify their behavior to ensure success at school and in life.

A student is eligible for this program under any of the following conditions:

1. Is charged with an off-campus felony and is awaiting adjudication.

2. Has been found guilty of a felony.

3. Has committed violations which may warrant expulsion according to the code of student conduct, as determined by the principal.

4. Poses an extreme threat of violence or vandalism.

5. Has a history of disruptive behavior (as documented by the records of student services personnel) which interferes with the student's own learning or the educational process of others.

6. Is transferring from a disciplinary alternative program in another district.

Students are assigned to the program for 45, 90, or 180 days as determined by the superintendent. They are evaluated at the end of the assignment to determine eligibility for return to the home school. Under certain circumstances an early return to the home may be granted.

ST COPY AVAILABLE

PROGRAM TITLE: HARRY SCHWETTMAN EDUCATION CENTER

DISTRICT: PASCO

Schwettman Education Center is a shining example of what's right with education. Looking for a positive way to impact an alternative education curriculum, a class was designed and implemented to teach the art of stained glass to disruptive students in grades 6 to 12. Schwettman Education Center created this innovative program with the purpose of teaching academic success and life skills through hands-on vocational training.

Since this program was unique to our county, it had to be built from the ground up. Schwettman staff developed a curriculum, designed and outfitted a glass studio, and sought school funds, as well as community endowments, to get the program established. After countless hours of planning and preparation, and the student-assisted renovation of a dilapidated building, Schwettman staff began teaching stained glass art to students.

In the beginning, classes were limited to one period each school day and held in an old, remodeled wood shop. Today, stained glass classes are scheduled for every class period and a new glass studio has replaced the old accommodations. After-school classes have been added for the convenience of community members and staff who have been inspired to learn the art of stained glass after observing their students' success .

Vocational classes in stained glass have been a powerful motivating force for students. These classes have helped many students change their view of education. They can see the value of learning a skill that merges academic substance with life skills training. The success of these stained glass classes have translated into personal success for students at Shcwettman Education Center.

PROGRAM TITLE: EXCEL MIDDLE AND HIGH SCHOOL

DISTRICT: SEMINOLE

EXCEL is a one-of-a-kind, nontraditional educational program designed to meet the needs of the at-risk population in middle and secondary schools. EXCEL services are contracted through the School Board of Seminole County and have been providing services to expelled students since 1994.

EXCEL operates as a business. From the time a student arrives at EXCEL, the business simulation model begins. Students punch a timeclock and use a professional planner to maintain a schedule, uphold their professional skills, and balance a behavioral budget system. All new students are required to successfully complete EXCEL Business Training (which consists of specific behavioral skills training) to advance to placement in the traditional EXCEL programs.

All students are assigned to a team and Team Leader. The students begin and end each day with their Team Leader and participate in a Team Building Class with their assigned team to develop the "soft skills" needed for social and professional development. Each student is issued a portfolio to guide them through their daily performance while participating in the program. Students are required to participate in SCANS 2000 competencies to acquire the skills necessary to be successful in school and in the work force.

Upon successful completion of EXCEL, students return to the zoned school and are assigned a Professional Development Trainer from the EXCEL staff. Trainers make visits to zoned schools on a biweekly basis to continue to provide encouragement and support for students. In addition, trainers provide SCANS and School-To-Work workshops in all Seminole County Public Schools. Students in grades K-12 experience professional development training on an as-needed basis.

BEST COPY AVAILABLE

PROGRAM TITLE: WAKULLA MIDDLE SCHOOL LONG TERM DISCIPLINARY PROGRAM

DISTRICT: WAKULLA

The Wakulla Middle School Long Term Disciplinary Program (LTDP) is an involuntary disciplinary program designed to serve a maximum of 30 students from grades 6-8. These students have been placed in LTDP due to disruptive or assaultive behavior, substance abuse, weapons on campus, or activities in or out of school which result in involvement with the criminal justice system. The usual minimum period for participation is thirty days.

The instructional component of this program is highly individualized, and is based upon the student's regularly scheduled classes. Additionally, computer-assisted basic skills remediation, geared to the specific abilities and needs of the student, is available. LTDP also has a positive behavior change component designed to teach coping and survival skills and to assist students in developing a positive attitude toward learning, the school environment, staff, other students, and themselves. This behavior program is designed to provide incentives that facilitate re-entry into the home school or another appropriate alternative program. A third component of the program is individual and group counseling.

Behavior and academic contracts are developed for each student. Adherence to these contracts and progress toward their completion are considered in any deliberation of the placement committee concerning reassignment to the regular classroom.

PROGRAM TITLE: IN SCHOOL SUSPENSION PROGRAMS - WALTON MIDDLE AND WALTON SENIOR HIGH SCHOOLS

DISTRICT: WALTON

This program is a short-term alternative to out-of-school suspension, and is designed to increase student academic performance and foster attitudes and behaviors necessary for success in the classroom. Students are assigned to the program for one to ten days. One self-contained classroom serves students in grades 6 through 8 at Walton Middle School. A second unit serves grades 9 through 12 at Walton Senior High. Students work independently on behavior modification units and academic course work. Regular classroom teachers work with the disciplinary teachers, assigning academic course work to be completed by the students during their stay in the disciplinary program. The students must satisfactorily complete the behavior modification units assigned before credit is awarded for academic course work. Individual and group counseling is included in the program and parental involvement is encouraged through conferences.

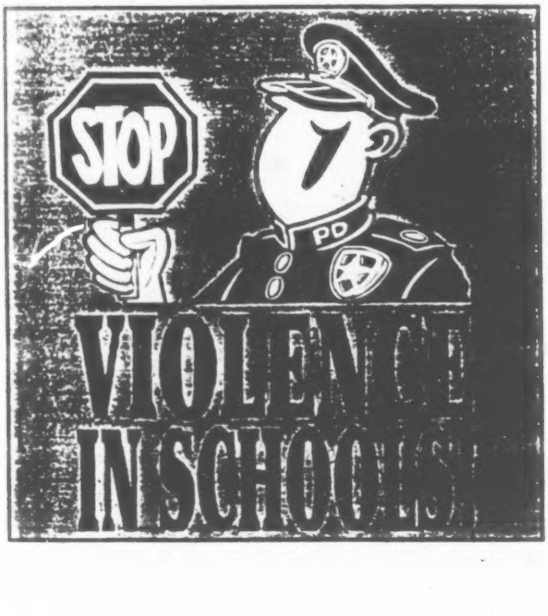
BEST COPY AVAILABLE

PROGRAM TITLE: OPTIONS
DISTRICT: WALTON

OPTIONS is a long term disciplinary program that serves Walton County Public Schools. The off-campus program serves approximately 50 students assigned by public school personnel in accordance with the District Code of Student Conduct. OPTIONS is funded by Walton County Schools and the Department of Juvenile Justice. Other agencies cooperating in the program's operation are the Walton County Sheriff's Department, the Concerned Community Fathers, Health and Rehabilitative Services, and Chautauqua Offices of Psychotherapy and Evaluation.

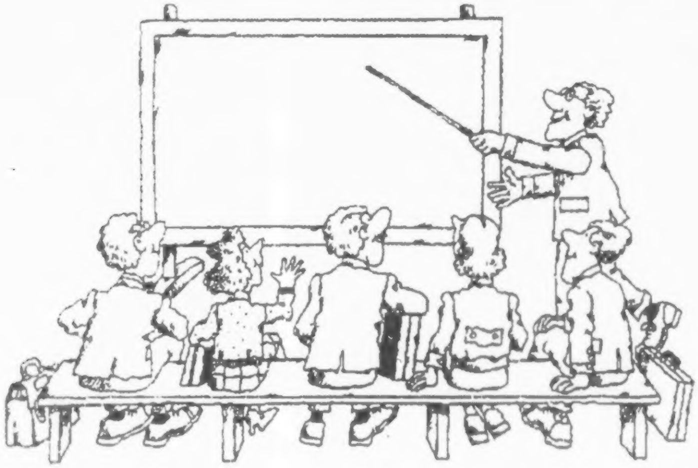
The program offers eligible students in grades 6-12 throughout the district an alternative to chronic suspension or expulsion. It is designed as an intermediate program for students whose behavior is too disruptive to remain in the regular classroom but does not qualify the student for youth services placement. The performance-based curriculum allows students to progress at their own speed. The program is enhanced by basic skills remediation, employability skills, and self-esteem building activities. Individual, group, and family counseling is provided.

The goal of the program is to provide a disciplinary alternative for students with severe behavior problems in an effort to modify their behavior to the extent that the student can return to the home school and eventually graduate.



EST COPY AVAILABLE

B. FACT SHEETS



- ANGRY CHILD
- ANGER CONTROL PROBLEMS
- BEHAVIORAL DISORDERS: FOCUS ON CHANGE
- BULLYING
- BULLYING IN SCHOOLS
- BULLYING: PEER ABUSE IN SCHOOLS
- CONDUCT DISORDERS (AACAP)
- CONDUCT DISORDER (NOAH)
- CONDUCT DISORDER (Research and Training Center)
- OPPOSITIONAL DEFIANT DISORDER
- TEMPER TANTRUMS

plain talk about...
dealing with the
ANGRY CHILD

NATIONAL INSTITUTE OF MENTAL HEALTH • Division of Communications and Education • Plain Talk Series • Ruth Key, editor

Handling children's anger can be puzzling, draining, and distressing for adults. In fact, one of the major problems in dealing with anger in children is the angry feelings that are often stirred up iri us. It has been said that we as parents, teachers, counselors, and administrators nebed to remind ourselves that we were not always taught how to deal with anger as a fact of life during our own childhood. We were led to believe that to be angry was to be bad, and we were often made to feel guilty for expressing anger.

It will be easier to deal with children's anger if we get rid of this notion. Our goal is not to repress or destroy angry feelings in children—or in ourselves—but rather to accept the feelings and to help channel and direct them Jo constructive ends.

Parents and teachers must allow children to feel all their feelings. Adult skills can then be directed toward showing children acceptable ways of expressing their feelings. Strong feelings cannot be denied, and angry outbursts should not always be viewed as a sign of serious problems; they should be recognized and treated with respect.

To respond effectively to overly aggressive behavior in children we need to have some ideas about what may have triggered an outburst. Anger may be a defense to avoid painful feelings; it may be associated with failure, low self-esteem,and feelings of isolation; or it may be related to anxiety about situations over which the child has no control.

Angry defiance may also be associated with feelings of dependency, and anger may be associated with sadness and depression. In childhood, anger and sadness are very close to one another and it is important to rember that much of what an adult experiences as sadness is expressed by a child as anger.

Before we look at specific ways to manage aggressive and angry outbursts, several points should be highlighted:

- We should distinguish between anger and aggression. Anger is a temporary emotional state caused by frustration; aggression is often an attempt to hurt a person or to destroy property.
- Anger and aggression do not have to be dirty words. In other words, in looking at aggressive behavior in children, we must be careful to distinguish between behavior that indicates emotional problems and behavior that is normal.

In dealing with angry children, our actions should be motivated by the need to protect and to teach, not by a desire to punish. Parents and teachers should show a child that they accept his or her feelings, while suggesting other ways to express the feelings. An adult might say, for example, "Let me tell you what some children would do in a situation like this . . ." It is not enough to tell children what behaviors we find unacceptable. We must teach them acceptable ways of coping. Also, ways must be found to communicate what we expect of them. Contrary to popular opinion, punishment is not the most effective way to communicate to children what we expect of them.

Responding to the Angry Child

Some of the following suggestions for dealing with the angry child were taken from *The Aggressive Child* by Fritz Redl and David Wineman. They should be considered helpful ideas and not be seen as a "bag of tricks."

- **Catch the child being good. Tell the child what behaviors please you.** Respond to positive efforts and reinforce good behavior. An observing and sensitive parent will find countless opportunities during the day to make such comments as, "I like the way you come in for dinner without being reminded"; "I appreciate your hanging up your clothes even though you were in a hurry to get out to play"; "You were really patient while I was on the phone"; "I'm dad you shared your snack with your sister"; "I like the way you're able to think of others"; and "Thank you for teeing the truth about what really happened."

Similarly, teachers can positively reinforce good behavior with statements like, "I know it was difficult for you to wait your turn, and I'm pleased that you could do it"; "Thanks for sitting in your seat quietly"; "You were thoughtful in offering to help Johnny with his spelling"; "You worked hard on that project, and I admire your effort."

Deliberately ignore inappropriate behavior that can be tolerated. This doesn't mean that you should ignore the child, just the behavior. The "ignoring" has to be planned and consistent. Even though this behavior may be tolerated, the child must recognize that it is inappropriate.

Provide physical outlets and other alternatives. It is important for children to have opportunities for physical exercise and movement, both at home and at school.

Manipulate the surroundings. Aggressive behavior can be encouraged by placing children in tough, tempting situations. We should try to plan the surroundings so that certain things are less apt to happen. Stop a "problem" activity and substitute, temporarily, a more desirable one. Sometimes rules and regulations, as wall as physical space, may be too confining.

Use closeness and touching. Move physically closer to the child to curb his or her angry impulse. Young children are often calmed by having an adult nearby.

Express interest in the child's activities. Children naturally try to involve adults in what they are doing, and the adult is often annoyed at being bothered. Very young children (and children who are emotionally deprived) seem to need much more adult involvement in their interests. A child about to use a toy or tool in a destructive way is sometimes easily stopped by an adult who expresses interest in having it shown to him. An outburst from an older child struggling with a difficult reading selection can be prevented by a caring adult who moves near the child to say, "Show me which words are giving you trouble."

Be ready to show affection. Sometimes all that is need can be tolerated d for any angry child to regain control is a sudden hug or other impulsive show of affection. Children with serious emotional problems, however, may have trouble accepting affection.

Ease tension through humor. Kidding the child out of a temper tantrum or outburst offers the child an opportunity to "save face." However, it is important to distinguish between face-saving humor and sarcasm or teasing ridicule.

Appeal directly to the child. Tell him or her how you feel and ask for consideration. For example, a parent or a teacher may gain a child's cooperation by saying, "I know that noise you're making doesn't usually bother me, but today I've got a headache, so could you find something else you'd enjoy doing?"

Explain situations. Help the child understand the cause of a stressful situation. We often fail to realize how easily young children can begin to react properly once they understand the cause of their frustration.

Use physical restraint. Occasionally a child may lose control so completey that he has to be physically restrained or removed from the scene to prevent him from hurting himself or others. This may also "save face" for the child. Physical restraint or removal from the scene should not be viewed by the child as punishment but as a means of saying, "You can't do that." In such situations, an adult cannot afford to lose his or her temper, and unfriendly remarkes by other children should not be tolerated.

Encourage children to see their strengths as well as their weaknesses. Help them to see that they can reach their goals.

Use promises and rewards. Promises of future pleasure can be used both to start and to stop behavior. This approacn should not be compared with bribery. We must know what the child likes—what brings him pleasure—and we must deliver on our promises.

Say "NO!" Limits should be clearly explained and enforced. Children should be free to function within those limits.

Tell the child that you accept his or her angry feelings, but offer other suggestions for expressing them. Teach children to put their angry feelings into words, rather than fists.

Build a positive self-image. Encourage children to see themselves as valued and valuable people.

Use punishment cautiously. There is a fine line between punishment that is hostile toward a child and punishment that is educational.

Model appropnate behavior. Parents and teachers should be aware of the powerful influence of their actions on a child's or group's behavior.

Teach children to express themselves verbally. Talking helps a child have control and thus reduces acting out behavior. Encourage the child to say, for example, "I don't like your taking my pencil. I don't feel like sharing just now."

The Role of Discipline

Good discipline includes creating an atmosphere of quiet firmness, clarity, and conscientiousness, while using reasoning. Bad discipline involves punishment which is unduly harsh and inappropriate, and it is often associated with verbal ridicule and attacks on the child's integrity.

As one fourth grade teacher put it: "One of the most important goals we strive for as parents, educators, and mental health professionals is to help children develop respect for themselves and others." While arriving at this goal takes years of patient practice, it is a vital process in which parents, teachers, and all caring adults can play a crucial and exciting role. In order to accomplish this, we must see children as worthy human beings and be sincere in dealing with them.

Adapted from "The Aggresive Child" by Luleen S. Anderson, Ph.D., which appeared in *Children today* (Jan-Feb 1978) published by the Children's Bureau, ACYF, DHEW. (Reprinting permission unnecessary.)

DHHS Publication No. (ADDS) 85-781
Printed 1978 Revised 1981 Reprinted 1985

Anger Control Problems

Andrea M. Mowatt
University of South Florida

Background—How do we define anger? **Anger is a social emotion,** involving some type of conflict between people (Bowers,1987), and because it allows people to identify and resolve sources of conflict, it is considered to be a normal part of our social interactions. More specifically, Novaco (1985) defines anger as a stress response that has three response components: cognitive, physiological, and behavioral. The cognitive component is characterized by a person's perceptions and interpretations of a social situation. The physical component of anger may involve an increase in both adrenaline flow and muscle tension. Behaviorally, anger is frequently seen in tantrum behaviors, yelling, hitting, and kicking. Children with anger control problems fall into two different categories: (a) those with a behavioral excess (anger is too intense, too frequent, or both), or (b) those with a behavioral deficit (an inability to express anger). Because anger can serve as a constructive force in relationships, children who are unable to express their anger in ways that facilitate conflict resolution are considered to have anger problems (Bowers, 1987).

Development—Behavioral manifestations of anger change from flailing arms and kicking legs in infancy to temper tantrums at 18 months, and finally, to verbal expressions of anger as a child's language skills develop (Gesell, Ilg, Ames, & Bullis, 1977). Tantrums usually appear during the second year, reach a peak by age 3, and are decreasing by age 4 (Bowers, 1991). How anger is expressed is learned by watching, listening to, or interacting with others and varies across and within cultures (Bowers, 1987). Because aggressive children are most often referred because of their behavior problems, the focus of the interventions offered below will deal with children who have excessive anger. Aggressive behavior, defined as the set of interpersonal actions that consist of verbal and physical behaviors that are destructive or injurious to others or to objects, is displayed by most children (Bandura, 1973; Lochman, 1984). Aggression poses a problem when it is exceptionally severe, frequent, and/or chronic (Lochman, White, & Wayland,1991). Children who display a wide range of different kinds of aggressive, antisocial behavior, and who are highly antisocial in multiple settings are at greatest risk for aggression problems in adulthood (Loeber & Schmaling, 1985), and for negative outcomes such as criminality, personality disorder, and substance abuse (Robins, 1978; Kandel, 1982; Lochman, 1990).

Causes—Feindler (1991) indicates that faulty perceptions, biases, beliefs, self-control deficits, and high states of emotional and physiological arousal contribute to the aggressive child's response to provocation. Aggressive youths generate fewer effective solutions and fewer potential consequences in hypothetical problem-solving situations (Asarnow & Callan, 1985), and display irrational, illogical, and distorted social information processing (Kendall, 1989).

What Should I Do as a Parent/Teacher?—The first step is to define and assess the situation. The following areas of investigation are suggested:

(1) What is the severity of the problem (frequency, intensity, duration, pervasiveness)?

(2) What factors may be causing the anger (e.g., academic frustration, grieving, illness, abuse problems with peers, parental divorce)?

(3) What happens after the child/adolescent has an outburst?

(4) What skills and attitudes do the child, family, and school bring to the intervention process?

An observation of specific behaviors used by the child and his/her peer group in the setting in which the problem behavior occurs is an important component of the assessment process. This allows a direct comparison of the child's behavior with his/her peer group. Recording the frequency, duration, and intensity of anger outbursts can provide further information- in addition, it may be beneficial to record descriptions of: (a) how the anger is manifested (e.g., hitting, yelling, threatening), (b) the setting in which the behavior occurs (e.g., time of day, location, type of activity), and (c) the events that occur before (stressors that provoke anger) and after the anger outburst (the consequences). Finally, normative measures (Feindler & Fremouw,1983), interviews (students, parents, and teachers), and an examination of self-monitoring and self-evaluation data (Feindler & Fremouw, 1983) often provide valuable information to the person(s) investigating the situation.

Once the problem has been defined, the following approaches are recommended:

(1) Try to keep your composure; it is important to appear approachable, empathetic, calm, and understanding (Bowers, 1987);

(2) Try to model the appropriate use of anger in situations where anger can be used to facilitate conflict resolution;

(3) Praise children when they are not angry (Bowers, 1987);

(4) Suggest that the explosive child temporarily leave the room to regain composure (Bowers, 1987);

(5) if further treatment is necessary, the following interventions have been suggested by Bower (1987):

(a) Stress-inoculation training, a procedure that allows the child/adolescent to acquire coping skills, including adaptive self-statements and relaxation. This three step process involves cognitive preparation, skills acquisition, and applied practice.

(b) Behavior modification strategies such as response cost, mediated essay, behavioral contracting, and direct reinforcement of alternative behavior (DRA) are often useful with nonverbal or noncompliant children; and

(c) Social skills training, which systematically teaches and reinforces behaviors that enhance social competence, can reduce the child's/adolescent's need to rely on anger for problem resolution.

Feindler (1991) suggests that there are five basic components of anger control training: "(1) arousal reduction, (2) cognitive change, (3) behavioral skills development, (4) moral reasoning development, and (5) appropriate anger expression." Feindler also suggests that there are a number of strategies that can be used to enhance the maintenance and generalization of anger control training techniques. For example, Feindler and her colleagues (i.e., Feindler, Marriott, & Iwata, 1984) have recommended the use of **group anger control training programs** over **individual anger control training programs.** They suggest that the role-played scenarios of conflict and the provocation that occur in the group training experience are more like the "real world" experiences that occur when the therapy session is over. **Incorporating strategies to enhance self-management (self-observation, self-recording,** self-reinforcement, and self-punishment) **and self-efficacy** (belief that the treatment will be effective and that the child can actually implement the skills) also seem to be imperative. In addition, the **use of contingency management** (e.g., cues in the **environment, goal-setting intervention, and** homework assignments), **and the inclusion of additional change agents** (e.g., staff members, parents, church youth groups, peer trainers, self-help groups) are believed to increase the effectiveness of the training.

Resources

Goldstein, A. P., Glick, B., Zimmerman, D., & Reiner, S. (1987). *Aggression replacement training: A comprehensive intervention for the acting-out delinquent.* Champaign, IL: Research Press.

Kendall, P. C. (Ed). (1991). *Child and adolescent therapy* (pp. 25-97). New York: Guilford Press.

Southern, S., & Smith, R. L. (1980). Managing stress and anxiety in the classroom. *Catalyst for* Change, 10, 4-7.

Tavris, C. (1982). Anger: *The misunderstood emotion.* New York: Simon & Schuster.

References

Asarnow, J. L., & Callan, J. W. (1985). Boys with peer adjustment problems: Social cognitive processes. *Journal of Consulting and Clinical Psychology, 53(1),* 80-87.

Bandura, A. (1973). *Aggression: A social learning analysis.* Englewood Cliffs, NJ: Prentice-Hall.

Bowers, R. C. (1987). Children and anger. In A. Thomas & J. Grimes (Eds.), *Children's needs: Psychological perspectives* (pp. 31-36). Washington, DC: NASP.

Feindler, E. L. (1991). Cognitive strategies in anger control interventions for children and adolescents. In P. C. Kendall (Ed.), *Child and adolescent therapy* (pp. 66-97). New York: Guilford Press.

Feindler, E. L., & Fremouw, W. J. (1983). Stress inoculation training for adolescent anger problems. In D. Meichenbaum & M. E. Jaremko (Eds.), *Stress reduction and prevention* (pp. 451-485). New York: Plenum.

Feindler, E. L., Marriott, S. A., & Iwata, M. (1984). Group anger control training for junior high school delinquents. *Cognitive Therapy and Research,* 8(3), 299-311.

Gesell, A., Ilg, F. L., Ames, L. B., & Bullis, G. E. (1977). *The child from five to ten* (rev. ed.). New York: Harper & Row.

Kandel, D. B. (1982). Epidemiological and psychosocial perspectives in adolescent drug abuse. *Journal of* the *American* Academy *of Child Psychiatry, 21,* 328-347.

Kendall, P. C. (1989). *Stop and think workbook.* (Available from the author, 238 Meeting House Lane, Merion Station, PA 19066)

Lochman, J. E. (1984). Psychological characteristics and assessment of aggressive adolescents. In C. R. Keith (Ed.), *The aggressive adolescent: Clinical perspectives* (pp. 17-62). New York: Free Press.

Lochman, J. E. (1990). Modification of childhood aggression. In M. Hersen, R. Eisler, & P. M. Miller (Eds.), *Progress in behavior modification* (Vol. 25). Newbury Park, CA: Sage.

Lochman, J. E., White, K. J., & Wayland, K. K. (1991). Cognitive-behavioral assessment and treatment with aggressive children. In P. C. Kendall (Ed.), *Child and adolescent therapy (pp.* 25-65). New York: Guilford Press.

Loeber, R., & Schmaling, K. B. (1985). Empirical evidence for overt and covert patterns of antisocial conduct problems: A meta analysis. *Journal of Abnormal Child Psychology, 13,* 337-352.

Novaco, R. W. (1985). Anger and its therapeutic regulation. In M. A. Chesney & R. H. Rosenman (Eds.), Anger *and hostility in cardiovascular and behavioral disorders.* New York: Hemisphere Publishing Corp.

Robins, L. N. (1978). Sturdy childhood predictors of adult antisocial behavior: Replications from longitudinal studies. *Psychological Medicine,* 8, 611 -622.

Behavioral Disorders: Focus on Change

ERIC Digest

FOCUS ON BEHAVIORS THAT NEED TO BE CHANGED

Students who are referred to as having "conduct disorders" and students who are referred to as having "emotional disabilities," "behavioral disorders," "serious emotional disturbances," or "emotional and behavioral disorders" have two common elements that are instructionally relevant: (1) they demonstrate behavior that is noticeably different from that expected in school or the community and (2) they are in need of remediation.

In each instance, the student is exhibiting some form of behavior that is judged to be different from that which is expected in the classroom. The best way to approach a student with a "conduct disorder" and a student with a "behavioral disorder" is to operationally define exactly what it is that each student does that is discrepant with the expected standard. Once it has been expressed in terms of behaviors that can be directly observed, the task of remediation becomes clearer. A student's verbally abusive behavior can be addressed, whereas it is difficult to directly identify or remediate a student's "conduct disorder," since that term may refer to a variety of behaviors of widely different magnitudes. The most effective and efficient approach is to pinpoint the specific behavioral problem and apply data-based instruction to remediate it. (Lewis, Heflin, & DiGangi, 1991, p.9)

IDENTIFY NEW BEHAVIORS TO BE DEVELOPED

Two questions need to be addressed in developing any behavior change procedure regardless of the student's current behavioral difficulty: "What do I want the student to do instead?" and "What is the most effective and efficient means to help the student reach his or her goals?" Regardless of whether the student is withdrawn or aggressive, the objective is to exhibit a response instead of the current behavior. We may want the student to play with peers on the playground instead of playing alone. We may want the student to play appropriately with peers on the playground instead of hitting peers during games. For both behavior patterns, we have identified what we want them to do instead of the current problem behavior. (Lewis, Heflin, & DiGangi, 1991, p.14)

Using effective teaching strategies will promote student academic and social behavioral success. Teachers should avoid focusing on students' inappropriate behavior and, instead, focus on desirable replacement behaviors. Focusing behavior management systems on positive, prosocial replacement responses will provide students with the opportunity to practice and be reinforced for appropriate behaviors. Above all else, have fun with students! Humor in the classroom lets students view school and learning as fun. Humor can also be used to avoid escalating behaviors by removing the negative focus from the problem. (Lewis, Heflin, & DiGangi, 1991, p.26).

PROVIDE OPPORTUNITIES TO PRACTICE NEW BEHAVIORS

If we expect students to learn appropriate social skills we must structure the learning environment so that these skills can be addressed and practiced. We need to increase the opportunity for students to interact within the school environment so that prosocial skills can be learned. If all a student does is perform as a passive participant in the classroom, then little growth in social skill acquisition can be expected. Just as students improve in reading when they are given the opportunity to read, they get better at interacting when given the opportunity to initiate or respond to others' interactions.

It is necessary to target specific prosocial behaviors for appropriate instruction and assessment to occur. Prosocial behavior includes such things as

- Taking turns, working with partner, following directions.
- Working in group or with others.
- Displaying appropriate behavior toward peers and adults.
- Increasing positive relationships.
- Demonstrating positive verbal and nonverbal relationships.
- Showing interest and caring.
- Settling conflicts without fighting.
- Displaying appropriate affect. (Algozzine, Ruhl, & Ramsey, 1991, pp. 22-23)

TREAT SOCIAL SKILLS DEFICITS AS ERRORS IN LEARNING

Social skills deficits or problems can be viewed as errors in learning; therefore, the appropriate skills need to be taught directly and actively. It is important to base all social skill instructional decisions on individual student needs. In developing a social skill curriculum it is important to follow a systematic behavior change plan.

During assessment of a student's present level of functioning, two factors should be addressed. First, the teacher must determine whether the social skill problem is due to a skill deficit or a performance deficit. The teacher can test the student by directly asking what he or she would do or can have the student role play responses in several social situations (e.g., "A peer on the bus calls you a name. What should you do?").

- If the student can give the correct response but does not display the behavior outside the testing situation, the social skill problem is probably due to a performance deficit.
- If the student cannot produce the socially correct response, the social skill problem may be due to a skill deficit.

More direct instruction may be required to overcome the skill deficits, while a performance deficit may simply require increasing positive contingencies to increase the rate of displaying the appropriate social response. During assessment, it is important to identify critical skill areas in which the student is having problems.

Once assessment is complete, the student should be provided with direct social skill instruction. At this point, the teacher has the option of using a prepared social skill curriculum or developing one independently. It is important to remember that since no single published curriculum will meet the needs of all students, it should be supplemented with teacher-developed or teacher-modified lessons.

Social skill lessons are best implemented in groups of 3 to 5 students and optimally should include socially competent peers to serve as models. The first social skill group lesson should focus on three things:

(1) an explanation of why the group is meeting,

(2) a definition of what social skills are, and

(3) an explanation of what is expected of each student during the group. It may also be helpful to implement behavior management procedures for the group (i.e., contingencies for for compliance and non-compliance).

It is important to prompt the students to use newly learned skills throughout the day and across settings to promote maintenance and generalization. It is also important to reinforce the students when they use new skills. (Lewis, Heflin, & DiGangi, 1991, pp.17-18)

TEACH STUDENTS TO TAKE RESPONSIBILITY FOR THEIR OWN LEARNING

Often overlooked is the need to increase student independence in learning. Students with BD may be particularly uninvolved in their learning due to problems with self-concept, lack of a feeling of belonging to the school, and repeated failures in school. Instructional strategies involving self-control, self-reinforcement, self-monitoring, self-management, problem solving, cognitive behavior modification, and metacognitive skills focus primarily on teaching students the skills necessary for taking responsibility and showing initiative in making decisions regarding their own instruction. These strategies, typically used in combination or in a "package format" that incorporates extrinsic reinforcement, have shown promise for enhancing student learning and independence. (Gable, Laycock, Maroney, & Smith, 1991, p.24)

FOCUS ON FUNCTIONAL SKILLS THAT WILL HAVE BROAD APPLICATIONS

Essential in a curriculum for students with behavioral problems are skills that can directly improve the ultimate functioning of the student and the quality of his or her life. The concept of functional skills is not limited to the areas of self-help or community mobility, but also include skills such as those required to seek and access assistance, be life-long independent learners, respond to changes in the environment, succeed in employment, be adequately functioning adults and parents, and achieve satisfying and productive lives. The concepts of the functional curriculum approach, the criterion of ultimate functioning, and participation to the highest degree possible in life must be extended to students with BD, many of whom will otherwise fail to fulfill their potential. (Gable, Laycock, Maroney, & Smith, 1991, p.28)

This digest was developed from selected portions of three 1991 ERIC publications listed below. These books are part of a nine-book series, "Working with Behavioral Disorders." Stock No. P346.

REFERENCES

Algozzine, B., Ruhl, K., & Ramsey, R. (1991). "Behaviorally disordered? Assessment for identification and instruction." Reston, VA: The Council for Exceptional Children. (ED No. 333660). Stock No. P339.

Gable, R. A., Laycock, V. K., Maroney, S. A., & Smith, C. R. (1991). "Preparing to integrate students with behavioral disorders." Reston, VA: The Council for Exceptional Children. (ED No. 333658). Stock No. P340.

Lewis, T. J., Heflin, J., & DiGangi, S. A. (1991). "Teaching students with behavioral disorders: Basic questions and answers." Reston, VA: The Council for Exceptional Children. (ED No. 333659). Stock No. P337.

OTHER RESOURCES

Brolin, D. E. (1992). "Life centered career education: Personal-social skills." Reston, VA: The Council for Exceptional Children. Stock No. P368.

Evans, W. H., Evans, S. S., & Shmid, R. E. (1989). "Behavior and instructional management: An ecological approach." Boston: Allyn and Bacon.

McIntyre, T. (1989). "The behavior management handbook: Setting up effective behavior management systems." Boston: Allyn and Bacon.

Meyen, E. L., Vergason, G. L., & Whelan, R. J. (Eds.) (1988). "Effective instructional strategies for exceptional children." Denver, CO: Love Publishing.

Morgan, D. P., & Jenson, W. R. (1988). "Teaching behaviorally disordered students: Preferred practices." Columbus, OH: Merrill.

Morgan, S. R., & Reinhart, J. A. (1991). "Interventions for students with emotional disorders." Austin, TX: ProEd.

Rockwell, S. (1993). "Tough to reach, Tough to teach: Students with behavior problems." Reston, VA: The Council for Exceptional Children. Stock No. P387.

=-=

ERIC Digests are in the public domain and may be freely reproduced and disseminated.

ED358674 Jun 93 Behavioral Disorders: Focus on Change. ERIC Digest #518.
Author: Council for Exceptional Children, Reston, Va.; ERIC Clearinghouse on Disabilities and Gifted Education, Reston, VA.

THIS DIGEST WAS CREATED BY ERIC, THE EDUCATIONAL RESOURCES INFORMATION CENTER. FOR MORE INFORMATION ABOUT ERIC, CONTACT ACCESS ERIC 1-800-LET-ERIC

This publication was prepared with funding from the Office of Educational Research and Improvement, U.S. Department of Education, under contract no. RI88062007. The opinions expressed in this report do not necessarily reflect the positions or policies of OERI or the Department of Education.

BULLYING

George Batsche, *University of South Florida*
Benjamin Moore, *Hommett School—The Baby Fold, Normal, Illinois*

Definition of a "Bully"—A bully is a child who fairly often oppresses or harasses someone else, the target may be boys or girls, the harrassment physical or mental (Olweus, D.). Bullies are usually boys, although girl bullies do exist.

Definition of a "Victim"—A child who for a fairly long time has been and still is exposed to aggression from others; that is, boys or possibly girls from the child's own class or maybe from other classes often pick fights and are rough with them or tease and ridicule them. Two types of "victims" emerge:

- "Passive Victims"—Anxious, insecure, appear to do nothing to invite attacks and fail to defend themselves.
- "Provocative Victims"—Hot-tempered, restless, create tension by irritating and teasing others and attempt to fight back when attacked.

Some facts about the bully problem

- Approximately **one in seven** school children is either a bully or a victim.
- This affects approximately 5,000,000 elementary and junior high school students in the United States.
- Approximately 282,000 students are physically attacked in America's secondary schools each month.
- An estimated 525,000 attacks, shakedowns and robberies occur in an average month in public secondary schools.
- In a typical month about 125,000 secondary school teachers (12 percent) are threatened with physical harm and approximately 5200 actually are physically attacked.
- **Almost 8 percent of urban junior and senior high school students miss one day of school each month because they are afraid to attend.**

➡ Why do some children and adolescents become bullies?

There is no "one reason why a child might become a bully. However, we do know what types of circumstances will likely help a child develop bully behavior. Bully behavior is developed mainly as a result of factors in the **environment.** This environment includes the home, the school and the peer group.

Bully behavior is learned. The good news is that because the bully behavior is learned, it can be unlearned, particularly if we do something about it when children are young.

What factors in the environment will likely contribute to a child becoming a bully?

- **Too little supervision of children and adolescents.** Without supervision, children do not get the message that aggressive behavior is the wrong behavior to have.

- **Bullying pays off.** Many children learn at a very young age that when they bully their brother, sister or parents that they get what they want. Often we are too busy or too tired to "fight" with the child so we just give in. Each time we give in when the child is aggressive or just plain obnoxious, we are giving the child the message that bullying pays off.

- **Do as I say, not as I do.** Some children seem more likely to imitate adult aggressive, bullying behavior than other children. In some families, when children are punished for aggressive behavior (even if they see it in their home) they stop being aggressive. For most children, however, if they see aggressive behavior they will imitate it. When parents fight and one parent intimidates the other and "wins,' the child gets the message that intimidation gets you what you want.

- **Harsh, physical punishment.** Although spanking a child will often put a stop to the child's behavior, spanking that is too harsh, too frequent or too physical teaches a child that it is OK to hit other people. In particular, this teaches a child that it is OK for bigger people (parents) to hit little people (children). **Bullies usually pick on younger, smaller, or weaker children.** They model, in their physical attacks, what happened to them **personally** in the home. **The worst thing that can be done is to physically punish a bully for bully behavior.**

- **Peer group that supports bully behavior.** Many parents do not know what their children are doing with the peer group. Their child may be running with other children who advocate bully behavior. In order for the child to "fit in," the child must bully like the peers.

- Getting more negative than positive messages. Children who develop bully behavior feel that the world around them (home, school, neighborhood) is more negative than positive. These children have more negative comments (get yelled at, told that they are wrong) than positive comments. They expect the world to be negative with them so they attack first. By picking on others, they feel more important and powerful. If they cannot feel important because parents and teachers make positive comments and "reinforce" them, then they will feel important in negative ways.

- **Poor self-concept.** Children who get more negative comments given to them than positive ones will develop a poor self-concept. These children then believe that the only way to be "accepted" is to pick on others.

- **Expecting hostility. Because of the negative messages received and the poor self-concept,** bullies expect their parents, teachers and peers to pick on them, blame them or otherwise humiliate them. Therefore, they attack before they are attacked, even when in reality they were not about to be attacked. They assume hostility when none exists. In many ways, the bully's philosophy is, **"The best defense is offense."**

➡ School factors

- Larger schools report a greater percentage of violence.
- Schools with clear rules of conduct enforced by the principal report less violence.
- Schools with students that report fair discipline practices report less violence.
- Small class size relates to less violence.
- Schools where students mention that they are in control of their lives report less violence.
- A principal who appears to be ineffective or invisible to students reports more violence in that school.
- Schools with principals that provide opportunities for the teachers and students to be participation members of decision-making report less violence.
- Cohesiveness among teaching staff and principal relate to less violence.

➡ Why do some children and adolescents become victims?

Less is really known about "victims but there is some information which will help us understand the victim situation to some extent.

- Most victims are anxious, sensitive, and quiet.

- Victims generally do not have many, if any, good friends at school.

- Victims seem to signal to others that they are insecure and worthless children who will not retaliate if they are attacked or insulted.

- Bullies often target children who complain, appear physically weak, seek attention from peers and adults and seem emotionally weak.

- These children may be overprotected by parents and school personnel and are therefore unable to develop coping skills on their own.

➥ What can be done about the problem?

In General

- A strong commitment is needed in the home and school to change the behavior. Parents need support from school and mental health/community workers to enforce positive behavior pattern. **Parent training is essential.**

- Specific training is needed in the social skills that the child lacks to get along with other children. This can be done in school through social skills training and in the home through increase in supervision, more positive discipline and modeling.

- Increase, significantly, the amount of positive feedback that the child gets in the home and the school.

- The pattern of bullying begins at an early age; as early as age 2. Early intervention is essential. The older the child becomes, the more difficult change will be. After age 8-10, change is very difficult.

- Develop a strong value system in the home and in the school that gives a clear message that bully behavior is completely unacceptable.

➥ Specifying things to do in the home

- If you have a serious bully or victim problem, contact the school psychologist in your child's school building and ask for help. In the meantime, the following steps will significantly help the problem

- Be sure that you are being as positive as possible with your child. Shoot for 5 positive comments for every negative one that you direct to your child. You will have to work very hard and " cacht them being good."

- Do not use physical punishment. Instead, use removal of privileges, time spent in their bedroom, work tasks around the house or helping younger children in the neighborhood or in the home a consequence for bully behavior.

- When you see your (or another) child engaging in bully behavior, put a stop to the behavior immediately and have the child practice a more appropriate behavior instead. For instance, if you have a child who pushes his sister away from a toy in order to play with it, have the child practice (at least 3 times) asking for (and receiving) the toy the correct way.

- If the child is a victim, have the child practice telling the bully to, ' stop bothering me" and then have the child walk away. The parent should be there to supervise the behavior of the bully and the victim.

- Parents must model, or show, the children in the home behavior between adults or between adults and children that is not bully behavior. If the children see parents yelling and bullying each other or if this is how the parent talks to the children, then the child will do that behavior as well. Remember to operate from the **"Do as I say AND as I do"** point of view.

- Supervision is of great importance. I' you can, supervise the situations in which your child Will have the opportunity to become either a bully or victim. If you cannot supervise the children under those circumstances, try to find someone who can. If you cannot supervise and cannot find someone, then do not allow the child to participate in that situation.

➥ Specific things to do in the school setting

- Establish a school climate that clearly and emphatically disapproves of bullying. This can be accomplished through school-wide campaigns (including contests, posters, parties, dances, school events) that support behaviors which are the opposite of bullying. These behaviors can include "buddy systems," cooperative learning, peer tutoring, big brother-big sister programs and others.

- Establish a climate in which rules of conduct are enforced and are developed by the students and teachers cooperatively.

- Discipline practices should emphasize restitution and positive practice rather than expulsion, paddlings, and humiliation. That is, when students are caught bullying they should apologize, demonstrate the correct behavior, and then have to spend a specified period of time helping (public service) younger, less able children.

• Teachers and administrators should work to increase the number of positives directed toward children on a daily basis. The ratio, just as in the home, should be approximately 5 positives for each negative. Teachers must **"catch them being good."** This may be difficult but the teacher will have to give positives for behaviors they usually take for granted. The situation may occur where the teacher will have to "set up" a situation in order to give positives. This might include sending an older "bully" to a younger class in order to help a particular student with an academic exercise. The "bully" can then receive recognition for this behavior.

• In classrooms where there are a number of students with the "bully" problem, the use of social skills training sessions throughout the year may be necessary. If the teacher is unfamiliar with these skill training sessions, a call to the school psychologist can help with materials and technical assistance.

• On a building level, the establishment of a "discipline" committee is suggested. The purpose of the committee would be to identify the five top discipline problems in the school and to develop intervention plans that will be implemented regardless of where in the school the problem behavior occurred. The discipline measures should emphasize restitution and positive practice, not physical punishment, exclusion, or humiliation.

• Although it is very difficult to justify, bullies should not be removed from the school setting unless absolutely necessary. The teaching of social skills, the value campaign against bully behavior and the increased number of positives directed toward bullies for appropriate behavior are more productive, in the long run, than exclusion.

The above are only examples of where to begin thinking about and acting on the problem. Listed below are resources for both parents and teachers.

Resources for parents and teachers

Parents

Available from: The National School Safety Center
Pepperdine University, Malibu, California 90265

- *School Crime and Violence: Victims' Rights*
- *Student and Staff Victimization* Resources on changing children s behavior in the home and family: **The following are available from any bookstore and can be ordered if not in stock.**

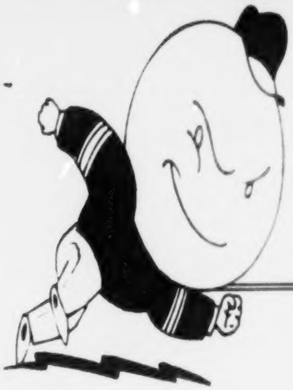
Available from: Research Press, Box 3177, Department 5, Champaign, IL 61826, (217) 352-3273.

- *Living with Children: New Methods for Parents and Teachers by Gerald R. Patterson.*
- *Parents are Teachers: A Child Management Program by Wesley C. Becker.*

Teachers

The information below is available from Research Press (see above).

- *Skillstreaming the Elementary School Child and Skillstreaming the Adolescent by Dr. Arnold Goldstein and colleagues.*
- *Aggressive Replacement Training by Dr. Arnold Goldstein and Dr. Barry Glick.*
- *The Prepare Curriculum: Teaching Prosocial Competencies by Dr. Arnold Goldstein.*
- *Getting Along with Others by Nancy F. Jackson, Dr. Donald A. Jackson and Cathy Monroe.*



Bullying in Schools

by Ron Banks

ED407154 Apr 97 Bullying in Schools. ERIC Digest. Author: Banks, Ron
ERIC Clearinghouse on Elementary and Early Childhood Education, Champaign, IL.

Bullying in schools is a worldwide problem that can have negative consequences for the general school climate and for the right of students to learn in a safe environment without fear. Bullying can also have negative lifelong consequences--both for students who bully and for their victims. Although much of the formal research on bullying has taken place in the Scandinavian countries, Great Britain, and Japan, the problems associated with bullying have been noted and discussed wherever formal schooling environments exist.

Bullying is comprised of direct behaviors such as teasing, taunting, threatening, hitting, and stealing that are initiated by one or more students against a victim. In addition to direct attacks, bullying may also be more indirect by causing a student to be socially isolated through intentional exclusion. While boys typically engage in direct bullying methods, girls who bully are more apt to utilize these more subtle indirect strategies, such as spreading rumors and enforcing social isolation (Ahmad & Smith, 1994; Smith & Sharp, 1994). Whether the bullying is direct or indirect, the key component of bullying is that the physical or psychological intimidation occurs repeatedly over time to create an ongoing pattern of harassment and abuse (Batsche & Knoff, 1994; Olweus, 1993).

EXTENT OF THE PROBLEM

Various reports and studies have established that approximately 15% of students are either bullied regularly or are initiators of bullying behavior (Olweus, 1993). Direct bullying seems to increase through the elementary years, peak in the middle school/junior high school years, and decline during the high school years. However, while direct physical assault seems to decrease with age, verbal abuse appears to remain constant. School size, racial composition, and school setting (rural, suburban, or urban) do not seem to be distinguishing factors in predicting the occurrence of bullying. Finally, boys engage in bullying behavior and are victims of bullies more frequently than girls (Batsche & Knoff, 1994; Nolin, Davies, & Chandler, 1995; Olweus, 1993; Whitney & Smith, 1993).

CHARACTERISTICS OF BULLIES AND VICTIMS

Students who engage in bullying behaviors seem to have a need to feel powerful and in control. They appear to derive satisfaction from inflicting injury and suffering on others, seem to have little empathy for their victims, and often defend their actions by saying that their victims provoked them in some way. Studies indicate that bullies often come from homes where physical punishment is used, where the children are taught to strike back physically as a way to handle problems, and where parental involvement and warmth are frequently lacking. Students who regularly display bullying behaviors are generally defiant or oppositional toward adults, antisocial, and apt to break school rules. In contrast to prevailing myths, bullies appear to have little anxiety and to possess strong self-esteem. There is little evidence to support the contention that they victimize others because they feel bad about themselves (Batsche & Knoff, 1994; Olweus, 1993).

Students who are victims of bullying are typically anxious, insecure, cautious, and suffer from low self-esteem, rarely defending themselves or retaliating when confronted by students who bully them. They may lack social skills and friends, and they are often socially isolated. Victims tend to be close to their parents and may have parents who can be described as overprotective. The major defining physical characteristic of victims is that they tend to be physically weaker than their peers--other physical characteristics such as weight, dress, or wearing eyeglasses do not appear to be significant factors that can be correlated with victimization (Batsche & Knoff, 1994; Olweus, 1993).

CONSEQUENCES OF BULLYING

As established by studies in Scandinavian countries, a strong correlation appears to exist between bullying other students during the school years and experiencing legal or criminal troubles as adults. In one study, 60% of those characterized as bullies in grades 6-9 had at least one criminal conviction by age 24 (Olweus, 1993). Chronic bullies seem to maintain their behaviors into adulthood, negatively influencing their ability to develop and maintain positive relationships (Oliver, Hoover, & Hazler, 1994).

Victims often fear school and consider school to be an unsafe and unhappy place. As many as 7% of America's eighth-graders stay home at least once a month because of bullies. The act of being bullied tends to increase some students' isolation because their peers do not want to lose status by associating with them or because they do not want to increase the risks of being bullied themselves. Being bullied leads to depression and low self-esteem, problems that can carry into adulthood (Olweus, 1993; Batsche & Knoff, 1994).

PERCEPTIONS OF BULLYING

Oliver, Hoover, and Hazler (1994) surveyed students in the Midwest and found that a clear majority felt that victims were at least partially responsible for bringing the bullying on themselves. Students surveyed tended to agree that bullying toughened a weak person, and some felt that bullying "taught" victims appropriate behavior. Charach, Pepler, and Ziegler (1995) found that students considered victims to be "weak," "nerds," and "afraid to fight back." However, 43% of the students in this study said that they try to help the victim, 33% said that they should help but do not, and only 24% said that bullying was none of their business.

Parents are often unaware of the bullying problem and talk about it with their children only to a limited extent (Olweus, 1993). Student surveys reveal that a low percentage of students seem to believe that adults will help. Students feel that adult intervention is infrequent and ineffective, and that telling adults will only bring more harassment from bullies. Students report that teachers seldom or never talk to their classes about bullying (Charach, Pepler, & Ziegler, 1995). School personnel may view bullying as a harmless right of passage that is best ignored unless verbal and psychological intimidation crosses the line into physical assault or theft.

INTERVENTION PROGRAMS

Bullying is a problem that occurs in the social environment as a whole. The bullies' aggression occurs in social contexts in which teachers and parents are generally unaware of the extent of the problem and other children are either reluctant to get involved or simply do not know how to help (Charach, Pepler, & Ziegler, 1995). Given this situation, effective interventions must involve the entire school community rather than focus on the perpetrators and victims alone. Smith and Sharp (1994) emphasize the need to develop whole-school bullying policies, implement curricular measures, improve the schoolground environment, and empower students through conflict resolution, peer counseling, and assertiveness training. Olweus (1993) details an approach that involves interventions at the school, class, and individual levels. It includes the following components:

- An initial questionnaire can be distributed to students and adults. The questionnaire helps both adults and students become aware of the extent of the problem, helps to justify interventionefforts, and serves as a benchmark to measure the impact of improvements in school climate onceother intervention components are in place.

- A parental awareness campaign can be conducted during parent-teacher conference days, through parent newsletters, and at PTA meetings. The goal is to increase parental awareness of the problem, point out the importance of parental involvement for program success, and encourage parental support of program goals. Questionnaire results are publicized.

- Teachers can work with students at the class level to develop class rules against bullying. Many programs engage students in a series of formal role-playing exercises and related assignments that can teach those students directly involved in bullying alternative methods of interaction. These programs can also show other students how they can assist victims and how everyone can work together to create a school climate where bullying is not tolerated (Sjostrom & Stein, 1996).

- Other components of anti-bullying programs include individualized interventions with the bullies and victims, the implementation of cooperative learning activities to reduce social isolation, and increasing adult supervision at key times (e.g., recess or lunch). Schools that have implemented Olweus's program have reported a 50% reduction in bullying.

CONCLUSION

Bullying is a serious problem that can dramatically affect the ability of students to progress academically and socially. A comprehensive intervention plan that involves all students, parents, and school staff is required to ensure that all students can learn in a safe and fear-free environment.

REFERENCES

Ahmad, Y., & Smith, P. K. (1994). Bullying in schools and the issue of sex differences. In John Archer (Ed.), *Male Violence*. London: Routledge.

Batsche, G. M., & Knoff, H. M. (1994). Bullies and their victims: Understanding a pervasive problem in the schools. *School Psychology Review, 23* (2), 165-174. EJ 490 574.

Charach, A., Pepler, D., & Ziegler, S. (1995). Bullying at school--a Canadian perspective: A survey of problems and suggestions for intervention. *Education Canada, 35* (1), 12-18. EJ 502 058.

Nolin, M. J., Davies, E., & Chandler, K. (1995). *Student Victimization at School*. National Center for Education Statistics--Statistics in Brief (NCES 95-204). ED 388 439.

Oliver, R., Hoover, J. H., & Hazler, R. (1994). The perceived roles of bullying in small-town Midwestern schools. *Journal of Counseling and Development, 72* (4), 416-419. EJ 489 169.

Olweus, D. (1993). *Bullying at School: What We Know and What We Can Do*. Cambridge, MA: Blackwell. ED 384 437.

Sjostrom, Lisa, & Stein, Nan. (1996). *Bully Proof: A Teacher's Guide on Teasing and Bullying for use withFourth and Fifth Grade Students*. Boston, MA: Wellesley College Center for Research on Women and the NEA Professional Library. PS 024 450.

Smith, P. K., & Sharp, S. (1994). *School Bullying: Insights and Perspectives*. London : Routledge. ED 387 223.

Whitney, I., & Smith, P. K. (1993). A survey of the nature and extent of bullying in junior/middle and secondary schools. *Educational Research, 35* (1), 3-25. EJ 460 708.

THIS DIGEST WAS CREATED BY ERIC, THE EDUCATIONAL RESOURCES INFORMATION CENTER. FOR MORE INFORMATION ABOUT ERIC, CONTACT ACCESS ERIC 1-800-LET-ERIC

References identified with an ED (ERIC document), EJ (ERIC journal), or PS number are cited in the ERIC database. Most documents are available in ERIC microfiche collections at more than 900 locations worldwide, and can be ordered through EDRS: (800) 443-ERIC. Journal articles are available from the original journal, interlibrary loan services, or article reproduction clearinghouses such as UnCover (800-787-7979), UMI (800-732-0616), or ISI (800-523-1850).

This publication was funded by the Office of Educational Research and Improvement, U.S. Department of Education, under contract no. RR93002007. The opinions expressed in this report do not necessarily reflect the positions or policies of OERI. ERIC Digests are in the public domain and may be freely reproduced.

Excerpts from

BULLYING:
PEER ABUSE IN SCHOOLS

U.S. Department of Education

Every day in our Nation's schools, children are threatened, teased, taunted and tormented by schoolyard bullies. For some children, bullying is a fact of life that they are told to accept as a part of growing up. Those who fail to recognize and stop bullying practices as they occur actually promote violence, sending the message to children that might indeed makes right.

Bullying often leads to greater and prolonged violence. Not only does it harm its intended victims, but it also negatively affects the climate of schools and the opportunities for all students to learn and achieve in school.

What Is Bullying?

Bullying among children is commonly defined as intentional, repeated hurtful acts, words or other behavior, such as name-calling, threatening and/or shunning committed by one or more children against another. These negative acts are not intentionally provoked by the victims, and for such acts to be defined as bullying, an imbalance in real or perceived power must exist between the bully and the victim.

Bullying may be physical, verbal, emotional or sexual in nature. For example:

- **Physical bullying** includes punching, poking, strangling, hair pulling, beating, biting and excessive tickling.
- **Verbal bullying** includes such acts as hurtful name calling, teasing and gossip.
- **Emotional bullying** includes rejecting, terrorizing, extorting, defaming, humiliating, blackmailing, rating/ranking of personal characteristics such as race, disability, ethnicity, or perceived sexual orientation, manipulating friendships, isolating, ostracizing and peer pressure.
- **Sexual bullying** includes many of the actions listed above as well as exhibitionism, voyeurism, sexual propositioning, sexual harassment and abuse involving actual physical contact and sexual assault.

Bullying among schoolchildren is quite common in the United States. In a study of junior high and high school students from small Midwestern towns, 88 percent of students reported having observed bullying, and 76.8 percent indicated that they had been a victim of bullying at school. Of the nearly 77 percent who had been victimized, 14 percent indicated that they experienced severe reactions to the abuse. A study of 6,500 fourth- to sixth-graders in the rural South indicated that during the three months preceding the survey, one in four students had been bullied with some regularity and that one in 10 had been bullied at least once a week. In the same survey, approximately one in five children admitted that they had bullied another child with some regularity during the three months preceding the survey.

Bullying also occurs under names. Various forms of hazing—including "initiation rites" perpetrated against new students or new members on a sports team—are nothing more than bullying. Same-gender and cross-gender sexual harassment in many cases also qualifies as bullying.

Who Is Hurt?

Bullying and harassment often interfere with learning. Acts of bullying usually occur away from the eyes of teachers or other responsible adults. Consequently, if perpetrators go unpunished, a climate of fear envelops the victims.

Victims can suffer far more than actual physical harm:

- Grades may suffer because attention is drawn away from learning.
- Fear may lead to absenteeism, truancy or dropping out.
- Victims may lose or fail to develop self-esteem, experience feelings of isolation and may become withdrawn and depressed.
- As students and later as adults, victims may be hesitant to take social, intellectual, emotional or vocational risks.
- If the problem persists, victims occasionally feel compelled to take drastic measures, such as vengeance in the form of fighting back, weapon-carrying or even suicide.
- Victims are more likely than nonvictims to grow up being socially anxious and insecure, displaying more symptoms of depression than those who were not victimized as children.

Bystanders and peers of victims can be distracted from earning as well. They may:

- Be afraid to associate with the victim for fear of lowering their own status or of retribution from the bully and becoming victims themselves;
- fear reporting bullying incidents because they do not want to be called a "snitch," a "tattler" or an "informer";
- experience feelings of guilt or helplessness for not standing up to the bully on behalf of their classmate;

- be drawn into bullying behavior by group pressure;
- feel unsafe, unable to take action or a loss of control.

Bullies themselves are also at risk for long-term negative outcomes. In one study, elementary students who perpetrated acts of bullying attended school less frequently and were more likely to drop out of school than other students. Several studies suggest that bullying in early childhood may be an early sign of the development of violent tendencies, delinquency and criminality.

A Comprehensive Approach:

Bullying and the harm that it causes are seriously underestimated by many children and adults. Educators, parents and children concerned with violence prevention must also be concerned with e phenomenon of bullying and its link to other violent behaviors.

Research and experience suggest that comprehensive efforts that involve teachers and other school staff, students, parents and community members are likely to be more effective than purely classroom-based approaches. Identified by the Center for the Study and Prevention of Violence as one of 10 model violence prevention proms is that of Norwegian researcher Dan Olweus. The U.S. application of his comprehensive model program included the following core elements.

School-level interventions

- Administration of a student questionnaire to determine the nature and extent of bullying problems at school.
- Formation of a bullying prevention coordination committee (a small group of energetic teachers, administrators, counselors and other school staff, who plan and monitor the school's activities.
- Teacher in-service days to review findings from the questionnaire, discuss problems of bullying, and plan the school's violence prevention efforts.
- School wide events to launch the program (e.g., via school television or assemblies).
- Increased supervision in areas that are hot spots for bullying and violence at the school.
- Development of school wide rules and sanctions against bullying.
- Development of a system to reinforce prosocial behavior (e.g., "Caught you Caring" initiatives).
- Parent involvement in school activities (e.g., highlighting the program at PTA meetings, school open houses, and special violence prevention programs; encouraging parents' participation in planning activities and school events).

Classroom Activities

- Regularly scheduled classroom meetings during which students and teachers engage in discussion, role-playing and artistic activities related to preventing bullying and other forms of violence among students.

Individual Interventions

- Immediate intervention by school staff in all bullying incidents.
- Involvement of parents of bullies and victims of bullying, where appropriate.
- Formation of "friendship groups" or other supports for students who are victims of bullying.
- Involvement of school counselors or mental health professionals, where appropriate.

Community Activities

- Efforts to make the program known among a wide range of residents in the local community (e.g., convening meetings with leaders of the community to discuss the school's program and problems associated with bullying, encouraging local media coverage of the school's efforts, engaging student in efforts to discuss their school's program with informal leaders of the community).
- Involvement of community members in the school's anti-bullying activities (e.g., soliciting assistance from local business to support aspects of the program, involving community members in school district wide "Bully-Free Day" events).
- Engaging community members, students, and school personnel in anti-bullying efforts within the community (e.g., introducing core program elements into summer church school classes).

Clearly, there is no "silver bullet" for preventing bullying other forms of violence at school. A comprehensive approach, such as this one, shows the most promise in helping to create a safe school environment that will help children to grow academically and socially. Before implementing any efforts to address bullying or other violence at school, school administrators should keep in mind that:

- Ideally, efforts should begin early—as children transition into kindergarten—and continue throughout a child's formal education;
- Effective programs require strong leadership and ongoing commitment on the part of school personnel;
- Ongoing staff development and training are important to sustain programs;
- Programs should be culturally sensitive to student diversity issues and developmentally appropriate; and
- Parental and community involvement in the planning and execution of such programs is critical.

Following are suggested action steps, strategies and resources that school administrators, educators, students and parents can employ in an effort to stop bullying in schools.

Action Steps for School Administrators

- Assess the awareness and the scope of the bullying problem at your school through student and staff surveys
- Closely supervise children on the playgrounds and in classrooms, hallways, rest rooms, cafeterias and other areas where bullying occurs in your school.
- Conduct school wide assemblies and teacher/staff in

service training to raise awareness regarding the problem of bullying and to communicate a zero tolerance for such behavior.

- Post and publicize clear behavior standards, including rules against bullying, for all students. Consistently and fairly enforce such standards.
- Encourage parent participation by establishing on campus parents' centers that recruit, coordinate and encourage parents to take part in the educational process and in volunteering to assist in school activities and projects.
- Establish a confidential reporting system that allows children to report victimization and that records the details of bullying incidents.
- Ensure that your school has all legally required policies and grievance procedures for sexual discrimination. Make these procedures known to parents and students.
- Receive and listen receptively to parents who report bullying. Establish procedures whereby such reports are investigated and resolved expeditiously at the school level in order to avoid perpetuating bullying.
- Develop strategies to reward students for positive, inclusive behavior.
- Provide school wide and classroom activities that are designed to build self-esteem by spotlighting special talents, hobbies, interests and abilities of all students and that foster mutual understanding of and appreciation for differences in others.

Strategies for Classroom Teachers

- Provide students with opportunities to talk about bullying and enlist their support in defining bullying as unacceptable behavior.
- Involve students in establishing classroom rules against bullying. Such rules may include a commitment from the teacher to not "look the other way" when incidents involving bullying occur.
- Provide classroom activities and discussions related to bullying and violence, including the harm that they cause and strategies to reduce them.
- Develop a classroom action plan to ensure that students know what to do when they observe a bully/ victim confrontation.
- Teach cooperation by assigning projects that require collaboration. Such cooperation teaches students how to compromise and how to assert without demanding. Take care to vary grouping of participants and to monitor the treatment of participants in each group.
- Take immediate action when bullying is observed. All teachers and school staff must let children know that they care and will not allow anyone to be mistreated. By taking immediate action and dealing directly with the bully, adults support both the victim and the witnesses.
- Confront bullies in private. Challenging a bully in front of his/her peers may actually enhance his/her status and lead to further aggression.
- Notify the parents of both victims and bullies when a confrontation occurs, and seek to resolve the problem expeditiously at school.
- Refer both victims and aggressors to counseling whenever appropriate.
- Provide protection for bullying victims, whenever necessary. Such protection may include creating a buddy system whereby students have a particular friend or older buddy on whom they can depend and with whom they share class schedule information and plans for the school day.
- Listen receptively to parents who report bullying and investigate reported circumstances so that immediate and appropriate school action may be taken.
- Avoid attempts to mediate a bullying situation. The difference in power between victims and bullies may cause victims to feel further victimized by the process or believe that they are somehow at fault.

Strategies for Students

Students may not know what to do when they observe a classmate being bullied or experience such victimization themselves. Classroom discussions and activities may help students develop a variety of appropriate actions that they can take when they witness or experience such victimization. For instance, depending on the situation and their own level of comfort, students can:

- seek immediate help from an adult;
- report bullying/victimization incidents to school personnel;
- speak up and/or offer support to the victim when they see him/her being bullied—for example, picking up the victim's books and handing them to him or her;
- privately support those being hurt with words of kindness or condolence;
- express disapproval of bullying behavior by not joining in the laughter, teasing or spreading of rumors or gossip; and
- attempt to defuse problem situations either singlehandedly or in a group—for example, by taking the bully aside and asking him/her to "cool it."

Strategies for Parents

The best protection parents can offer their children who are involved in a bully/victim conflict is to foster their child's confidence and independence and to be willing to take action when needed. The following suggestions are offered to help parents identify appropriate responses to conflict experienced by their children at school:

- Be careful not to convey to a child who is being victimized that something is wrong with him/her or that he/she deserves such treatment. When a child is subjected to abuse from his or her peers, it is not fair to fault the child's social skills. Respect is a basic right: All children are entitled to courteous and respectful treatment. Convince your child that he or she is not at fault and that the bully's behavior is the source of the problem.
- It is appropriate to call the school if your child is involved in a conflict as either a victim or a bully. Work collaboratively with school personnel to address the problem. Keep records of incidents so that you can be specific in your discussion with school personnel about

your child's experiences at school.

- You may wish to arrange a conference with a teacher, principal or counselor. School personnel may be able to offer some practical advice to help you and your child. They may also be able to intervene directly with each of the participants. School personnel may have observed the conflict firsthand and may be able to corroborate your child's version of the incident, making it harder for the bully or the bully's parents to deny its authenticity.
- While it is often important to talk with the bully or his/ her parents, be careful in your approach. Speaking directly to the bully may signal to the bully that your child is a weakling. Speaking with the parents of a bully may not accomplish anything since lack of parental involvement in the child's life is a typical characteristic of parents of bullies. Parents of bullies may also fail to see anything wrong with bullying, equating it to "standing up for oneself."
- Offer support to your child but do not encourage dependence on you. Rescuing your child from challenges or assuming responsibility yourself when things are not going well does not teach your child independence. The more choices a child has to make, the more he or she develops independence, and independence can contribute to self-confidence.
- Do not encourage your child to be aggressive or to strike back. Chances are that it is not his or her nature to do so. Rather, teach your child to be assertive. A bully often is looking for an indication that his/her threats and intimidation are working. Tears or passive acceptance only reinforces the bully's behavior. A child who does not respond as the bully desires is not likely to be chosen as a victim. For example, children can be taught to respond to aggression with humor and assertions rather than acquiescence.
- Be patient. Conflict between children more than likely will not be resolved overnight. Be prepared to spend time with your child, encouraging your child to develop new interests or strengthen existing talents and skills that will help develop and improve his/her self esteem. Also help your child to develop new or bolster existing friendships. Friends often serve as buffers to bullying.
- If the problem persists or escalates, you may need to seek an attorney's help or contact local law enforcement officials. Bullying or acts of bullying should not be tolerated in the school or the community. Students should not have to tolerate bullying at school any more than adults would tolerate such situations at work.

Classroom Resources

Both bullies and their victims need help in learning new says to get along in school. Children need to learn about training, using and abusing power and about the differences between negotiating and demanding. They must also learn to consider the needs, behaviors and feelings of others. Curriculum developers and publishers now offer a variety of prevention/intervention materials to eliminate bullying and other forms of personal conflict from school life. Curricula such as those listed below are examples of tools that may be used as *part* of a comprehensive approach to bullying:

- *No Bullying.* This Johnson Institute curriculum, first Implemented during the 1996-97 school year in schools across the country, describes the tell-or-tattle dilemma facing many victims of bullying. Teachers are given step-by-step guidelines on how to teach students the difference between telling and tattling. Teachers are also shown how to establish and use immediate consequences when dealing with bullies.
- *Bullyproof: A Teacher's Guide on Teasing and Bullying for Use with Fourth and Fifth Grade Students.* This guide by Lisa Sjostrom and Nan Stein contains 11 sequential lessons designed to help children understand the difference between teasing and bullying and to gain awareness about bullying and harassment through class discussions, role-play and writing, reading and art exercises.
- *Bully-Proofing Your School.* This program, available from Sopris West, uses a comprehensive approach. Key elements include conflict resolution training for all staff members, social skills building for victims, positive leadership skills training for bullies, intervention techniques for those who neither bully nor are bullied and the development of parental supporter
- *Quit it! A Teacher's Guide on Teasing and Bullying.* This guide by Merle Frosche, Barbara Spung, and Nancy Mullin-Rindler with Nan Stein contains 10 lesson plans. Each lesson is divided into activities geared to the developmental needs of students in kindergarten through third grade. Class discussions, role plays, creative drawing and writing activities, physical games and exercises and connections to children's literature give children a vocabulary and a conceptual framework that allows them to understand the distinction between teasing and bullying.
- *Second Step.* The Committee for Children's Second Step curriculum teaches positive social skills to children and families, including skill building in empathy, impulse control, problem solving and anger management. Initial evaluations of *Second Step* indicate that second and third grade students engaged in more prosocial behavior and decreased physically aggressive behavior after participating in the program.6
- "Bullying." This video and accompanying teacher's guide (produced by South Carolina's Educational Television in collaboration with the Institute for Families in Society at the University of South Carolina) contains five lesson plans that incorporate classroom discussions, role playing and artistic exercises. It is appropriate for older elementary and middle-school students.

In the effort to make schools and communities safer, educators, parents and concerned citizens are encouraged to support school wide programs that address bullying. As part of this school wide effort, adults—including bus drivers, playground supervisors, hall monitors, security officers, cafeteria workers, maintenance personnel, clerical staff, teachers, parent volunteers, counselors and administrators—must present a united front that communicates to all students that bullying will not be tolerated at school.

Innovative Approaches to Bully Prevention

School-based bullying prevention programs across the United States vary a great deal in their target populations, their comprehensiveness and the specific approaches they take. When considering use of a given curriculum or program to eliminate bullying, request from the publisher evaluation data and names of persons to contact for information about the effectiveness of the program, its procedures and materials.

Additional Resources

- Bitney, James. No *Bullying*. Minneapolis, Minn.: The Johnson Institute.
- *Bullying: Dontr Suffer in Silence. An Anri-Bullying Pack for Schools* London: HMSO Publications, 1994.
- California Association of School Psychologists. "The Good, The Bad And The Bully." *Resource Paper* April 1997: 1-8.
- Edmondson, Daisy. "Bullies." *Parents* April 1988: 100 106.
- Eron, Leonard D. "Aggression through the ages." *School Savagery* Fall 1987: 12-16.
- Foltz-Gray, Dorothy. "The Bully Trap." *Teaching Tolerance* Fall 1996: 19-23.
- Franklin, Deborah. "Charm School for Bullies." *Hippocrates* May/June 1989: 75-77.
- Fried, SuEllen and Paula Fried. *Bullies & Victims: Helping Your Child Through the Schoolyard Battlefield*. New York: M. Evans and Company, Inc., 1996.
- Gabarino, James. *Let's Talk Aoout Living in a World With Violence*, available from Erikson Institute, Suite 600, 420 North Wabash Avenue, Chicago, IL 60611.
- Carrity, Carla, Kathryn Jens, William Porter, Nancy Sager and Cam Short-Camilli. *Bully-Proofing Your* School: A *Comprehensive Approach for Elementary Schools*. Longmont, Colo: Sopris West, 1994.
- Greenbaum, Stuart, Brenda Turner and Ronald D. Stephens. *Set Straight on Bullies*. Malibu, Calif.: Pepperdine University Press, 1989.
- Hazler, Richard J. "Bullying Breeds Violence: You Can Stop It!" *Learning* February 1994: 38-40.
- Hodges, Ernest V.E. and David G. Perry. Victimization is Never Just Child's Play." *School Safety* Fall 1996: 4 7, 30.
- Hodges, Ernest V.E. and David G. Perry. "Victims of Peer Abuse: An Overview." *Reclaiming Children and Youth* Spring 1996: 23-28.
- Hoover, John H. and Ronald Oliver. *The Bullying Prevention Handbook: A Guide for Principals, reachers, and Counselors*. Bloomington, Ind.: National Educational Service, 1996.
- Huggins, Pat. "The Assist Program," a series of nine books to promote students' self-esteem and build interpersonal skills. Titles include *Teaching Friendship Skills* (primary and intermediate ver-sions); *Helping Kids Handle Anger; Helping Kids Find Their Strengths; Building Self-Esteem in the Classroom (primary* and intermediate versions); *Teaching Cooperation Skills; Creating a Caring Classroom; Teaching About Sexual Abuse*. Longmont, Colo.: Sopris West.
- Jenson, William R., Ginger Rhode and H. Kenton Reavis. *The Tough Kid Book*. Longmont, Colo.: Sopris West, 1994.
- Limber, Susan P. "Bullying among schoolchildren." *School Safety* Fall 1996: 8-9, 30.
- McCoy, Elin. •'Bully-Proof Your Child." *Readers Digest* November 1992: 199-204.
- Olweus, Dan. *Bullying at school: What we know and what we can do*. NY: Blackweli, 1993.
- Olweus, Dan. "Bully/Victim Problems at School: Facts and Effective Intervention." *Reclaiming Children and Youth* Spring 1996: 15-22.
- Olweus, Dan. "Schoolyard bullying—grounds for intervention." *School Safety* Fall 1987: 4- 11.
- Olweus, Dan. Aggression *in the Schools: Bullies and Whipping Boys*. Washington, D.C.: Hemisphere, 1978.
- Perry, David G. How is aggression learned?" *School Safety* Fall 1987: 23-25.
- Rhode, Ginger, William R. Jenson and H. Kenton Reavis. *The Tough Kid Book: Practical Classroom Management Strategies* Longmont, Colo.: Sopris West, 1992.
- Roberts, Marjory. "School Yard Menace." *Psychology Today* February 1988: 52-56.
- Ross, Dorothea M. *Childhood Bullying and Teasing: What School Personnel, Other Professionals, and Parents Can Do* Alexandria, Va.: American Counseling Association, 1996.
- Saunders, Carol Silverman. "Taming Your Child's Bully." Good *Housekeeping* November 1995: 206.
- Sheridan, Susan M. *The Tough Kid Social Skills Book*, Longmont, Colo.: Sopris West,
- Sjostrom, Lisa and Nan Stein. *Bullyproof: A Teacher's Guide on Teasing and Bullying for Use with Fourth and Fifth Grade Students* Wellesley, Mass.: Center for Research on Women, 1996.
- Skinner, Alison. *Bullying: An annotated bibliography of literature and resources* Leicester, England: Youth Work Press, 1992.
- Smotherman, Jill. "Help for victims and bullies: 'tease out' success potential." *School Safety* Fall 1996: 10- 12.
- Sousa, Chris, Mary Sousa and Carol Peters. •-Parents become advocates to fight disruption, violence." *School Safety* Fall 1996: 24-29.
- STOP Violence Coalition. *Kindness is Contagious Catch it!* available from STOP Violence Coalition, 301 E. Armour, Suite 205, Kansas City, MO 64111.
- Tattum, Delwyn and Graham Herbert. *Countering Bullying: Initiatives IVY Schools and Local Authorities* Stoke-on-Trent, England: Trentham Books, 1993.
- Tattum, Delwyn and David A. Lane, eds. *Bullying in Schools* Stoke-on-Trent, England: Trentham Books, 1989.
- Teel Institute for the Development of Integrity and Ethical Behavior. *Project Essential*, available from Teel Institute for the Development of Integrity and Ethical Behavior, 101 E. Armour Blvd., Kansas City, MO 64111 - 1203.
- Robin, Tary and Larry K. Irvin. •8The Olweus BullyMctim Ouestionnaire." *Reclaiming Children and Youth* Spring 1996: 29-33.
- Walsleben, Marjorie Creswell. "Bully-free schools: What you can do." *School Safety* Fall 1996: 13-15.
- Webster-Doyle, Terrence and Adryan Russ. *Why is Everybody Always Picking on Me: A Special Curriculum for Dung People to Help Them Cope with Bullying* Middlebury,

Vt.: Atrium Society Publications, 1994.

- Weinhold, Barry K., ad. *Spreading Kindness: A Program Guide Nor Reducing Youth and Peer Violence in the Schools,* avail-able from The Kindness Campaign, c/o the C.U. Foundation, Uni-versity of Colorado, Colorado Springs. P.O. Box 7150, Colorado Springs, CO 80933.

Bullying videos

•'Bully." 1973. National Instructional Television Center, Box A, Bloomington, IN 47401.

- "Bullying." 1995. South Carolina Educational Television, PO Box 11000, Columbia, SC 29211.
- "Bully Smart." 1995, Street Smart,105 North Virginia Avenu, Suite 305, Falls Chutch, VA22042
- "Broken Toy." 1993. Summerhills Productions, 846-Mcintire Ave., Zanesville, Ohio, 43701.It

"Coping with Bullying." 1991. James Stanfield Company,Drawer G. P.O. Box 41058, Santa Barbara, Calif., 93140.

- "Dealing with Bullies, Troublemakers and Dangerous Situations" (Part of the PeaceTalks series). The Bureau for At-Risk Youth, 135 Dupont St., P.O. BOX 760, Plainview, N.Y., 11803-0760.
- "Don't Pick on Me." 1993. Sunburst Communications, 101 Castleton St., Pleasantville, N.Y., 10570.
- "Groark Learns About Bullying'- (Volume 4 in the Prevent Violence with Groark series). Wisconsin Clearinghouse for Pre-vention Resources, University Health Services, University of Wisconsin-Madison, Dept. 7B, P.O. Box 1468, Madison, Wis., 53701 - 1468.
- "Michael's Story: The No Blame Approach." 1990. Lame Duck Publishing, 71 South Road, Portshead, Bristol BS20 90Y, England.
- "Set Straight on Bullies." 1988. National School Safety Center, 4165 Thousand Oaks Blvd., Suite 290, Westlake Village, Ca-lif., 91362.
- "Stamp Out Bullying." 1990. Lame Duck Publishing, 71 South Road, Portshead, Bristol BS20 90Y, England.

Bullying books for children

- Alexander, Martha. *Move Over Twer/**. New York: Dial, 1981.
- Berenstain, Stan and Jan Berenstain. *She Beren.vtain Bears and the Bully.* New York: Random House, 1993.
- Bosch, Carl W. *Bully on the Bus.* Seattle: Parenting Press, 1988.
- Bottner, B. *Mean Maxine.* New York: Pantheon, 1980.
- Boyd, L. *Baily the Big Bully* New York: Puffin Books, 1991.
- Carlson , Nancy. *Loudmouth* George *anti the Sixths tirade Bully.* New York: Puffin Books, 1985.
- Carrick, Carol. *What a Wimp!* New York: Clarion Books, 1983.
- Chapman, C. *Herbies troubles.* New York: Dutton Children'sBooks, 1981.
- Cohen-Posey, Kate. *Hot!* to *handle Bullies Teasers and Other Meanies: A Book that Takes the Nuisance Out of Name Calling and* Other *Nonsense.* Highland City, Fla.: Rainbow Books, 1995.
- Cole, J. *Bully 7roul)le.* New York: Random House, 1989.
- Coombs, Karen Mueller. Beating *Bully O Brien.* New York: Avon, 1991.
- Cushman, D. *Camp* Big Paw. New York: Harper & Row, 1990.
- Dinardo, Jeffrey. Timothy *and* the Big *Bully.* New York: Simon & Schuster, 1988.
- Freshet, B. *Furlie Cat.* New York: Lothro.p, 1986.
- Henkes, K. *Chrysanthemum.* New York: Greenwillow Books, 1991.
- Naylor, Phyllis Reynolds. *Reluctantly Alice.* New York: Dell, 1992.
- Rosenberg, Liz. *Monster Mama.* New York: Philomel Books, 1993.
- Shreve, Susan. Joshua T. *Bates Takes Charge.* New York: Alfred A. Knopf, Inc., 1993.
- Stoltz, Mary. *Tale Bully of Barkham Street.* New York: Harper & Row, 1985.
- Walker, Alice. *Finding the Green Stone.* San Diego: Harcourt Brace Jovanovich, 1991.
- Webster-Doyle, Terrence. *Why is Everybody Always Picking on Me: A Guide to Understanding Bullie.v Jbr Young People.* Middlebury, Vt.: Atrium Society Publications, 1991.
- Wilhelm, Hans. *Tyrone the horrible.* New York: Scholastic, Inc., 1988.
- Williams, Karen Lynn. First *Grade King.* New York: Clarion Books, 1992.

Endnotes

1. J.H. Hoover, R. Oliver, and R.I. Hazier. "Bullying: Perceptions of adolescent victims in the Midwestern USA," School *Psychology lnternarional* 13: 5- 16, 1992.

2. S.P. Limber, P. Cumlingham, V. Florx, 1. Ivey. M. Nation, S. Chai, and G. Melton, "Bullying among school children: Preliminary findings from a school-based intervention program," paper presented at the Fifth International Family Violence Research Conference, Durham, NH, June/July 1997.

3. Carol Chmelynski, "School boards fight back against hazing," *School Board News. 13:12* May 1997.

4. B.J. Byrne, "Bullies and victims in school settings with refer ence to some Dublin schools," *Irish Journal of Psyc/lology* 15:574-586, 1994.

5. Dan Olwous, 'Victimization by peers: Antecedents and long term outcomes," in *Social Withdrawal. Inhibition,* ***and Shyne.vs,*** edited by K.H. Rubin and J.B. Asendorf, Hillsdale, N.J.: Erlbaum, 1993, pp. 315-341.

L.D. Eron, L.R. Husemann, E. Dubow, R. Romanoff, and P.W. Yarmel, •'Aggression and its correlates over 22 years," in *Child-hood Aggression and Violence: Sources of 'ln]luence, Prevention and Control,* edited by D.H. Crowell, I.M. Evans, and C.R. O'Donnell, New York: Plenum, 1987, pp. 249-262.

6. D.C. Grossman et al., "Effectiveness of a violence prevention curriculum among children in elementary school," *Journal of the American Medical Association,* 277: 1605-1611, 1997.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

Facts for Families *Fact sheets are available online at http://www.aacap.org/publications/pubcat/facts.htm or contact AACAP Public Information, P.O. Box 96106, Washington, D.C. 20090-6106.*

CONDUCT DISORDERS

"Conduct disorders" are a complicated group of behavioral and emotional problems in youngsters. Children and adolescents with these disorders have great difficulty following rules and behaving in a socially acceptable way. They are often viewed by other children, adults and social agencies as "bad" or delinquent, rather than mentally ill.

Children or adolescents with conduct problems may exhibit some of the following behaviors:

Aggression to people and animals

- ➤ bullies, threatens or intimidates others
- ➤ often initiates physical fights o uses weapon that could cause serious physical harm to
- ➤ others (e.g. a bat, brick, broken bottle, knife or gun)
- ➤ is physically cruel to people or animals
- ➤ steals from a victim while confronting them (e.g. assult)
- ➤ forces someone into sexual activity

Destruction of Property

- ➤ deliberately engages in fire setting with the intention to cause damage deliberately
- ➤ destroys other's property

Deceitfulness, lying, or stealing

- ➤ breaks into someone else's building, house, or car
- ➤ lies to obtain goods, or favors or to avoid obligations
- ➤ steals items without confronting a victim (e.g. shoplifting, but without breaking and entering)

Serious violations of rules

- ➤ often stays out at night despite parental objections
- ➤ runs away from home
- ➤ often truant from school

Research shows that the future of these youngsters is likely to be very unhappy if they and their families do not receive early, ongoing and comprehensive treatment. Without treatment, many youngsters with conduct disorders are unable to adapt to the demands of adulthood and continue to have problems with relationships and holding a job. They often break laws or behave antisocially. Many children with a conduct disorder may be diagnosed as also having a coexisting depression or an attention deficit disorder.

Many factors may lead to a child developing conduct disorders, including brain damage, child abuse, defects in growth, school failure and negative family and social experiences. The child's "bad" behavior causes a negative reaction from others, which makes the child behave even worse.

Treatment of children with conduct disorders is difficult because the causes of the illness are complex and each youngster is unique. Treatment can be provided in a variety of different treatment settings depending on the severity of the behaviors. Adding to the challenge of treatment are the child's uncooperative attitude, fear and distrust of adults. In order to form a comprehensive treatment plan, a child and adolescent psychiatrist may use information from other medical specialists, and from the child, family and teachers to understand the causes of the disorder.

Behavior therapy and psychotherapy are usually necessary to help the child appropriately express and control anger. Remedial education may be needed for youngsters with learning disabilities. Parents often need expert assistance in devising and carrying out special management and educational programs in the home and at school. Treatment may also include medication in some youngsters, such as those with difficulty paying attention and controlling movement or those having an associated depression.

Treatment is rarely brief since establishing new attitudes and behavior patterns takes time. However, treatment offers a good chance for considerable improvement in the present and hope for a more successful future.

=-

Facts for Families © is developed and distributed by the American Academy of Child and Adolescent Psychiatry. Facts sheets may be reproduced for personal or educational use without written permission, but cannot be included in material presented for sale or profit.

Copyright © 1997 by the American Academy of Child & Adolescent Psychiatry.

THE NEW YORK HOSPITAL
CORNELL MEDICAL CENTER

FACT SHEET: CONDUCT DISORDER

Definition

Conduct Disorder is a persistent pattern of behavior in which a child or adolescent ignores the basic rights of others and breaks major norms or rules of society.

Symptoms

Symptoms of this disorder may include stealing; running away; lying; fire-setting; truancy; breaking and entering; destruction of property; physical cruelty to animals or people; forcing sexual activity on others; using weapons in fights; frequent physical fights; drug or alcohol abuse; cheating in games and/or at school; manipulating or taking advantage of others; verbally or physically bullying; intimidating or threatening others; frequent outbursts; impairment in social, school or occupational functioning; staying out late at night despite parental prohibition (under age 13); or disobeying rules.

Cause

The cause of conduct disorder is unknown at this time. The following are some of the theories being investigated:

1. It may be related to the child's temperament and the family's response to that temperament.
2. It may be that a predisposition to conduct disorder is inherited in some families.
3. There may be neurological causes.
4. It may be caused by a chemical imbalance in the brain

Course

The course of conduct disorder is variable. Mild forms tend to improve over time. More severe forms (those that require hospitalization or day hospital treatment) are more likely to be prolonged. Without treatment, the severe forms can lead to illegal or criminal activity and can be complicated by chemical abuse or dependence, school suspension, sexually transmitted diseases, unwanted pregnancy, high rates of physical injury from accidents, imprisonment, fights and suicidal behaviors. With treatment, reasonable social and occupational adjustment can be made in adulthood.

Treatment

Treatment of conduct disorder often consists of group, individual and/or family therapy and education about the disorder; structure; support; limit-setting; discipline; consistent rules; identification with role models; social skills training; behavior modification; remedial education (when needed); and sometimes residential or day treatment or medication.

Self-Management

Some of the measures a person with conduct disorder and his or her family can take to maximize social and vocation adjustment include:

1. Attending therapy sessions.
2. Using time-outs.
3. Identifying what increases anxiety.
4. Talking about feelings instead of acting on them.
5. Finding and using ways to calm oneself.
6. Frequently reminding oneself of one's goals.
7. Getting involved in tasks and activities that direct one's energy.
8. Learning communication skills.
9. Developing a predictable daily schedule of activity.
10. Developing ways to obtain pleasure that do not interfere with the rights of others.
11. Learning social skills.
12. Establishing mutually acceptable limits of behavior and consistently reinforcing those limits.

Dealing with Relapse

During a period of good adjustment, the patient and his family and the therapist should make a plan for what steps to take if signs of relapse appear. The plan should include what specific symptoms are an important warning signs that immediate measures must be taken to prevent relapse. An agreement should be made to call the therapist at once when those specific symptoms occur, and at the same time to notify friends and other people who can help. Concrete ways to limit stress and stimulation and to provide structure should be planned during a stable period.

=-

The New York Hospital / Cornell Medical Center
Westchester Division / Department of Psychiatry
21 Bloomingdale Road, White Plains, NY 10605

For information or referral, call 1-888-694-5780

Copyright © 1996 by The New York Hospital-Cornell Medical Center, Department of Psychiatric Nursing, last revised 5/98

Research and Training Center
ON FAMILY SUPPORT & CHILDREN'S MENTAL HEALTH

http://www.rtc.pdx.edu:80/index.htm

CONDUCT DISORDER

→DESCRIPTION / SYMPTOMS / DIAGNOSIS

Conduct disorder is a persistent pattern of conduct in which the basic rights of others and major age-appropriate societal norms or rules are violated. The behaviors must occur over time, not just be isolated antisocial acts. Symptoms begin during childhood or adolescence.

Conduct disorders may be mild, moderate or severe in nature. Mild forms tend to dissipate as a child matures, but more severe forms are often chronic. Conduct disorders appear in many settings, including the home, the school, with peers, and in the community. Children with conduct disorders are often physically aggressive and cruel to other people and animals. They may set fires, steal, mug, or snatch purses. In later adolescence, they may commit more serious crimes such as rape, assault, or armed robbery. These children typically lie and cheat in games and in schoolwork are often truant and may run away from home. Children with conduct disorders often show no concern for the feelings of others and fail to show remorse or guilt for harm they have inflicted.

A child is labeled conduct disordered if he or she meets specific behavioral criteria. These children project an image of toughness, but usually have low self-esteem. They often have other difficulties as well, such as depression, low problem-solving skills, learning disorders, and problems with substance abuse. A large number of these children are also diagnosed as having attention-deficit/hyperactivity disorder.

→CAUSATION/INCIDENCE

There are various factors that may predispose children and youth to the development of conduct disorders. Most believe that it is a complex interaction of numerous biological, interpersonal, and environmental factors. Developmental disorders and mental retardation we commonly found in conjunction with conduct disorders. Social stressors often include difficulties in the home, a parental history of alcohol dependence, and economic factors. The disorder can begin before puberty. Childhood onset is more commonly seen in boys and adolescent onset is seen more commonly in girls. Approximately 9 percent of boys and 2 percent of girls under age 18 are thought to have the disorder in the United States, conduct disorders are becoming more common for both sexes and are being seen in younger children. Conduct disorders that are severe enough to result in arrests have been increasing in recent years.

→TREATMENT

Just as there are many potential factors which predispose a youngster to the development of conduct disorder, there are also many forms of treatment. Some are directed toward the child (individual therapy, behavioral therapy, training in problem solving), the family (parent management training, family therapy), the peer group (group therapy), and community-based interventions (recreation and youth centers). At present, none of these forms of treatment have had more than limited success. Behavior modification and group counseling have had limited success during treatment, but there is no evidence that they provide long term benefits. Among the family therapies, only functional family therapy (FFT), an integrative approach based on behavioral techniques presented in a family systems context, has had positive outcomes. A goal of FFT is to improve the communication and support of the family. It also appears that a combination of parent management training (PMT) and problem-solving skills training for children has medium range positive effects on behavior.

➔ROLE OF FAMILY/IMPACT ON FAMILY

Life with a child who has a serious emotional disorder mats be associated with a number of troubling and conflicting feelings: love, anger, anxiety, grief, guilt, fear, and depression. These feelings are not unusual; most parents find it is helpful to share these feelings with someone else--family, friends, a support group, or some other informal group. Parents need to realize the scope and limitations of their responsibility and learn to take care of themselves as well as their child. Professional help in the form of individual, couples, or family counseling may be helpful in providing emotional support, guidance, and help in the child's recovery.

➔REFERENCES AND BIBLIOGRAPHY

American Psychiatric Association (1994). *Diagnostic and statistical manual of mental disorders (R-IV)* Washington, D.C.: American Psychiatric Association.

Horne, A.M. & Sayger, T.V. (1990). *Treating conduct and oppositional defiant disorders in children* New York: Pergamon Press.

Institute of Medicine, Division of Mental Health and Behavioral Medicine. (1989). *Research on children and adolescents with mental behavioral and developmental disorders: Mobilizing a national initiative* Washington, DC: National Academy Press.

Kazdin, A.E. (1987). *Conduct disorders in childhood and adolescence* Developmental Clinical Psychology and Psychiatry Series, Volume 9. Newbury Park: Sage Publications

Kazdin, A.E. (1990). Conduct disorder in childhood. In M. Hersen & C.G. Last (Eds.), *Handbook of child and adult psychopathology: A longitudinal perspective* New York: Pergamon Press.

Mash, E.J. & Terdal, L.G. (Eds.) (1988). *Behavioral assessment of childhood disorders*, 2nd edition. New York: The Guilford Press.

Prange, M.E., Greenbaum, P.E., Johnson, M.E. & Friedman, AM. (1991). Persistence of conduct disordered diagnoses among adolescents with serious emotional disturbances. In A. Algarin & RIM. Friedman (Eds.), *A system of care for children's mental health: Expanding the research base* Tampa, Florida: University of South Florida.

Rapoport, J.L. & Ismond, D.R. (1990). *DSM-III-R training guide for diagnosis of childhood disorders.* New York: Brunner/Mazel Publishers.

Tunler, F.J. (Ed.) (1989). *Child psychopathology: A social work perspective* New York: The Free Press.

=.

Prepared by the Research and Training Center on Family Support and Children's Mental Health, Portland State University, P.O. Box 751, Portland, Oregon 97207-0751; (503) 725 4040. If you wish to reprint this information and share it with others, please acknowledge its preparation by the Research and Training Center.

September 1994

http://noah.cuny.edu/illness/mentalhealth/cornell/conditions/odd.html
Ask NOAH About: Mental Health

THE NEW YORK HOSPITAL
CORNELL MEDICAL CENTER

FACT SHEET: OPPOSITIONAL DEFIANT DISORDER

Definition

Oppositional Defiant Disorder is a persistent pattern (lasting for at least six months) of negativistic, hostile, disobedient, and defiant behavior in a child or adolescent without serious violation of the basic rights of others.

Symptoms

Symptoms of this disorder may include the following behaviors when they occur more often than normal for the age group: losing one's temper; arguing with adults; defying adults or refusing adult requests or rules; deliberately annoying others; blaming others for their own mistakes or misbehavior; being touchy or easily annoyed; being angry and resentful; being spiteful or vindictive; swearing or using obscene language; or having a low opinion of oneself. The person with Oppositional Defiant Disorder is moody and easily frustrated, has a low opinion of him or herself, and may abuse drugs.

Cause

The cause of Oppositional Defiant Disorder is unknown at this time. The following are some of the theories being investigated:

1. It may be related to the child's temperament and the family's response to that temperament.
2. A predisposition to Oppositional Defiant Disorder is inherited in some families.
3. There may be neurological causes.
4. It may be caused by a chemical imbalance in the brain.

Course

The course of Oppositional Defiant Disorder is different in different people. It is a disorder of childhood and adolescence that usually begins by age 8, if not earlier. In some children it evolves into a conduct disorder or a mood disorder. Later in life, it can develop into Passive Aggressive Personality Disorder or Antisocial Personality Disorder. With treatment, reasonable social and occupational adjustment can be made in adulthood.

Treatment

Treatment of Oppositional Defiant Disorder usually consists of group, individual and/or family therapy and education, providing a consistent daily schedule, support, limit-setting, discipline, consistent rules, having a healthy role model to look up to, training in how to get along with others, behavior modification, and sometimes residential or day treatment and/or medication.

Self-Management

To make the fullest possible recovery, the person must:

1. Attend therapy sessions.
2. Use self time-outs.
3. Identify what increases anxiety.
4. Talk about feelings instead of acting on them.
5. Find and use ways to calm oneself.
6. Frequently remind oneself of one's goals.
7. Get involved in tasks and physical activities that provide a healthy outlet for one's energy.
8. Learn how to talk with others.
9. Develop a predictable, consistent, daily schedule of activity.
10. Develop ways to obtain pleasure and feel good.
11. Learn how to get along with other people.
12. Find ways to limit stimulation.
13. Learn to admit mistakes in a matter-of-fact way.

Dealing with Relapse

During a period of good adjustment, the patient and his family and the therapist should plan what steps to take if signs of relapse appear. The plan should include what specific symptoms are an important warning of relapse. An agreement should be made to call the therapist immediately when those specific symptoms occur, and at the same time to notify friends and other people who can help. Specific ways to limit stress and stimulation and to make the daily schedule more predictable and consistent should be planned during a stable period.

=-

The New York Hospital / Cornell Medical Center
Westchester Division / Department of Psychiatry
21 Bloomingdale Road, White Plains, NY 10605
For information or referral, call 1-888-694-5780
Copyright © 1996 by The New York Hospital-Cornell Medical Center, Department of Psychiatric Nursing, last revised 5/98

Children and Temper Tantrums

THEO LEXMOND

BARRY INTERMEDIATE SCHOOL DISTRICT, HASTINGS, MICHIGAN

Background

One of the most unsettling periods in a child's life, and certainly one of the most unnerving periods for parents, is the stage of development often referred to as "the terrible twos." The behavior that makes "the terrible twos' so terrible for many toddlers and their parents is the arrival of temper tantrums. Many children develop some form of temper tantrum behavior during their toddler years. Though two-year-olds seem to be especially prone to temper tantrums, tantrum behavior characteristic of "the terrible twos" may occur in children of any age.

Temper tantrums can include relatively mild behaviors such as pouting, whining, crying, and name calling. They can also include more disruptive behaviors such as screaming, kicking, punching, scratching and biting, and even self-injurious behaviors like head banging and holding one's breath to the point of fainting.

For most young children, the development of tantrums is only a temporary stopping point along the path of learning how to cope with frustration. For others, temper tantrums become a block to further emotional growth and development. The difference between tantrum behavior that is a step toward maturity and tantrum behavior that becomes a block to further growth lies in the way parents and caretakers deal with their youngster's tantrums.

Development

Why do many children display temper tantrums in the course of normal development?

The world is an exciting place for toddlers. Their ability to crawl, and later to walk, allows them to reach and explore any area they can see. Toddlers are constantly getting into things that their parents would prefer they left alone. In addition to their improved ability to move around and explore things, toddlers also grow rapidly in their ability to understand and use words. The growth of their vocabulary allows them to express their needs and to understand simple commands. The combination of these two factors, increased ability to move around and increased understanding of words, leads to an event that toddlers find very frustrating: the introduction of verbal rule training by their parents.

Verbal rule training is the flood of necessary do's and don'ts that parents shower upon their toddlers in order to protect them from harm and to keep them out of mischief. "Don't touch!" "Don't go in there!" "Don't hit!" "Don't cry!" "Do eat your carrots.' "Do be quiet." "Do put that away." "Do be good." These are just a few examples of the many commands that toddlers face each day.

Though infants learn to talk instead of gurgling and babbling, they never give up smiling, laughing, frowning or crying as ways of communicating how they feel. Crying or screaming by a two or three-year-old communicates frustration in a way with which the youngster is familiar. The experience of verbal rule training can be very frustrating to toddlers. In response to this frustration toddlers will often revert to screaming and crying to proclaim to the world that they are "fed-up." An occasional outburst of screaming or crying by a two or three-year-old child is not an uncommon or worrisome occurrence. A child of this age finds it hard to accept brief frustrations and putting these frustrations into words is an equally difficult task.

If a period of tantrum behavior is normal for many children, how do I tell the difference between "normal" tantrums and tantrum behavior that I should be worried about?

The best way to answer this question is to take a close look at your child s tantrum behavior and the behavior of you and your family when tantrums occur. Do any of these things happen in your family?

✓ Your child has tantrums in many settings, not just at home.

✓ Your child has tantrums regardless of who in the family is caring for the youngster.

✓ Your child is having more and more tantrums each day as time goes on.

✓ Your child's tantrums are becoming more severe as time goes on.

✓ Your child hurts him or herself or tries to hurt others during tantrums.

✓ Your child receives extra attention from family members when a tantrum occurs. For example, when your child has a tantrum someone hugs or holds the child, or perhaps someone scolds or lectures the child.

✓ Members of your family try to stop your child's tantrums by giving the youngster what he or she wants.

✓ Members of your family avoid taking a tantrum-prone child grocery shopping, to church, to visit friends or relatives, out to eat, etc., because they are afraid the child will tantrum in those settings.

✓ You find it hard to get someone to babysit your tantrum-prone child.

If one or more of the items above describe the experience your family is having, your child may be developing a severe tantrum problem.

A severe tantrum problem is characterized by tantrum behavior that has become goal directed. When children first develop tantrums, they use crying and screaming as a way of expressing frustration. Tantrums start out as a way for children to communicate that they are "fed up" with the limits placed upon them. If children learn, however that having tantrums can gain them extra attention from their family or can allow them to do things they would not otherwise be allowed to do, their tantrums will come to serve a different purpose. No longer will they use tantrums simply as a means of expressing frustration. Instead, such children will use tantrums as a tool for obtaining more attention and getting to do more things. Their tantrums will become goal directed.

Family members and other caretakers cause tantrums to become goal directed, usually without realizing they are doing so. If a child, for example, cries and screams because he desires a toy that is currently out of reach, hugging and rocking the child until he is calm will soothe the youngster for the moment, but will encourage him to cry and scream in the future when something else he wants is out of reach. Even though he/she was not given the toy as a result of his tantrums, he/she received a great deal of special attention. By repeating this pattern over and over again, family members may actually teach a child to have tantrums as a way of obtaining something he or she wants. This is not to say that children should never be soothed when they are upset. The key point to remember is that children should not be allowed to use tantrums as a way of getting special treatment from those around them.

What Can I Do As A Parent?

Whether tantrum behaviors are just beginning to develop in your child, or tantrums have become a long standing problem, there are actions you and members of your family can take to help your child gain control over tantrum behavior.

Some *guidelines for dealing with tantrum behaviors when they first begin to develop.*

✓ Rule out the possibility that tantrums are being caused by a factor other than general frustration with verbal rule training. Some factors which may cause or contribute to tantrums include teething, the presence of seizure activity, the side effects of some medications, or a sudden emotional loss such as the death or long absence of a parent. In the vast majority of cases, tantrums are the result of frustration encountered in daily living. If a specific cause, such as one of those mentioned above is suspected, you should have your child evaluated by an appropriate health care professional.

✓ Do not allow your child to receive extra attention from family members as a result of having a tantrum.

✓ Do not allow your child to obtain things he or she would not otherwise be allowed to obtain as a result of having a tantrum.

✓ Do not scold or spank your child for having a tantrum. Scolding or spanking is likely to reinforce tantrum behavior and cause it to get worse.

✓ Tantrums are not an appropriate way of asking for a desired object. Even if the object is something your child would normally be allowed to have, do not allow the child to obtain it by having a tantrum. Provide the object only when the child is calm and has asked for it in an appropriate fashion, considering the child's age.

✓ Do not ignore your child when the youngster is being good because you are afraid of "setting the child off" and causing a tantrum to occur. Pay extra attention to your child when he or she is behaving appropriately and is not having a tantrum.

Some guidelines for dealing with tantrum behavior that has become a serious, long standing problem.

✓ If tantrum behaviors have become a severe problem for your child, arrange to visit with a child care professional such as a school psychologist or clinical child psychologist. A trained child care professional can help you develop a program that will deal with the specific circumstances of your child's situation. Tantrum behaviors that are deeply entrenched do not yield to "quick fix" solutions. A professional child care worker can help you to develop a comprehensive plan for dealing with severe tantrum behavior and can demonstrate the special skills you will need in order to help your child get tantrums under control. There are effective techniques available for dealing with tantrums that occur at home, in school, in public places such as grocery stores and restaurants, and for dealing with bedtime tantrums as well.

✓ As mentioned earlier, you should not scold or spank your child for having a tantrum. Scolding or spanking is likely to reinforce tantrum behavior and cause it to get worse.

✓ Try to pay extra attention to your child when he or she is not having tantrums. By making yourself available when your child is behaving well, you teach your child that special attention can be gained by a means other than having tantrums.

Resources

Living With Children—by G. R. Patterson. Research Press, Publisher, 1976. Chapter 14 of Patterson's book provides a model of a simple program for dealing with tantrums occurring in the home.

Living With a Brother or Sister With Special Needs: A Book for Sibs—by D. J. Meyer, P. F. Vadasy and R. R. Fewell. University of Washington Press, Publisher 1985. This resource book, written for children of late elementary school age and older has a section devoted specifically to the questions children have regarding the role they must play in dealing with the behavior problems of a brother or sister.

Tantrums, Jealousy and the Fears of Children—by L. Barrow, A. H. & A. W. Reed, Publisher 1968. This booklet in Barrow's series on child psychology provides a brief discussion of temper tantrum development in young children and includes descriptions by parents of tantrum problems they have dealt with in their own families.

C. A Few More Resources from Our Center

UCLA Center for Mental Health in Schools
Relevant Center Materials

The mission of the Center is to improve outcomes for young people by enhancing policies, programs, and practices relevant to mental health in schools in schools.

Under the auspices of the School Mental Health Project in the Department of Psychology, our Center approaches mental health and psychosocial concerns from the broad perspective of addressing barriers to learning and promoting healthy development. Specific attention is given to policies and strategies that can counter fragmentation and enhance collaboration between school and community programs.

A partial list...

I. Introductory Packets

Working Together: From School-Based Collaborative Teams to School-Community-Higher Education Connections

This packet discusses the processes and problems related to working together at school sites and in school-based centers. It also outlines models of collaborative school-based teams and interprofessional education programs*.

Violence Prevention and Safe Schools

This packet outlines selected violence prevention curricula and school programs and school-community partnerships for safe schools. It emphasizes both policy and practice.

Least Intervention Needed: Toward Appropriate Inclusion of Students with Special Needs

This packet highlights the principle of *least intervention needed* and its relationship to the concept of *least restrictive environment.* From this perspective, approaches for including students with disabilities in regular programs are described.

Parent and Home Involvement in Schools

This packet provides an overview of how home involvement is conceptualized and outlines current models and basic resources. Issues of special interest to under-served families are addressed.

Assessing to Address Barriers to Learning

This packet discusses basic principles, concepts, issues, and concerns related to assessment of various barriers to student learning. It also includes resource aids on procedures and instruments to measure psychosocial, as well as environmental barriers to learning.*

*You may download the indicated documents through our website at: http://smhp.psych.ucla.edu

Cultural Concerns in Addressing Barriers to Learning

This packet highlights concepts, issues and implications of multiculturalism/cultural competence in the delivery of educational and mental health services, as well as for staff development and system change. It also includes resource aids on how to better address cultural and racial diversity in serving children and adolescents.*

Dropout Prevention

This packet highlights intervention recommendations and model programs, as well as discusses the motivational underpinnings of the problem.*

Learning Problems and Learning Disabilities

This packet identifies learning disabilities as one highly circumscribed group of learning problems, and outlines approaches to address the full range of problems.*

Teen Pregnancy Prevention and Support

This packet covers model programs and resources and offers an overview framework for devising policy and practice.*

II. Resource Aid Packets

Screening/Assessing Students: Indicators and Tools

This packet is designed to provide some resources relevant to screening students experiencing problems. In particular, this packet includes a perspective for understanding the screening process and aids for initial problem identification and screening of several major psychosocial problems.*

Responding to Crisis at a School

This packet provides a set of guides and handouts for use in crisis planning and as aids for training staff to respond effectively. It contains materials to guide the organization and initial training of a school-based crisis team, as well as materials for use in ongoing training, and as information handouts for staff, students, and parents.*

Addressing Barriers to Learning: A Set of Surveys to Map What a School Has and What It Needs

This packet provides surveys covering six program areas and related system needs that constitute a comprehensive, integrated approach to addressing barriers and thus enabling learning. The six program areas are (1) classroom-focused enabling, (2) crisis assistance and prevention, (3) support for transitions, (4) home involvement in schooling, (S) student and family assistance programs and services, and (6) community outreach for involvement and support (including volunteers).*

Students and Psychotropic Medication: The School's Role

This packet underscores the need to work with prescribers in ways that safeguard the student and the school. It contains aids related to safeguards and for providing the student, family, and staff with appropriate information on the effects and monitoring of various psychopharmacological drugs used to treat child and adolescent psycho-behavioral problems.*

*You may download the indicated documents through our website at: http://smhp.psych.ucla.edu

Substance Abuse

This packet offers some guides to provide schools with basic information on widely abused drugs and indicators of substance abuse. It also includes some assessment tools and reference to prevention resources.*

Clearinghouse Catalogue

Our Clearinghouse contains a variety of resources relevant to the topic of mental health in schools. This annotated catalogue classifies these materials, protocols, aids, program descriptions, reports, abstracts of articles, information on other centers, etc. under three main categories: policy and system concerns, program and process concerns, and specific psychosocial problems. (Updated regularly)*

Catalogue of Internet Sites Relevant to Mental Health in Schools

This catalogue contains a compilation of Internet resources and links related to addressing barriers to student learning and mental health in schools. (Updated regularly)*

Organizations with Resources Relevant to Addressing Barriers to Learning: A Catalogue of Clearinghouses, Technical Assistance Centers, and Other Agencies

This catalogue categorizes and provides contact information on organizations focusing on children's mental health, education and schools, school-based and school-linked centers, and general concerns related to youth and other health related matters. (Updated regularly)*

Where to Get Resource Materials to Address Barriers to Learning

This resource offers school staff and parents a listing of centers, organizations, groups, and publishers that provide resource materials such as publications, brochures, fact sheets, audiovisual & multimedia tools on different mental health problems and issues in school settings.*

III. Technical Aid Packets

School-Based Client Consultation, Referral, and Management of Care

This aid discusses why it is important to approach student clients as consumers and to think in terms of managing *care*, not *cases*. It outlines processes related to problem identification, triage, assessment and client consultation, referral, and management of care. It also provides discussion of prereferral intervention and referral as a multifaceted intervention. It clarifies the nature of ongoing management of care and the necessity of establishing mechanisms to enhance systems of care. It also provides examples of tools to aid in all these processes ware included.*

School-Based Mutual Support Groups (For Parents, Staff; and Older Students)

This aid focuses on steps and-tasks related to establishing mutual support groups in a school setting. A sequential approach is described that involves (1) working within the school to get started, (2) recruiting members, (3) training them on how to run their own meetings, and (4) offering off-site consultation as requested. The specific focus here is on parents; however, the procedures are readily adaptable for use with others, such as older students and staff.*

---

*You may download the indicated documents through our website at: http://smhp.psych.ucla.edu

Volunteers to Help Teachers and School Address Barriers to Learning

This aid outlines (a) the diverse ways schools can think about using volunteers and discusses how volunteers can be trained to assist designated youngsters who need support, (b) steps for implementing volunteer programs in schools, (c) recruitment and training procedures and (d) key points to consider in evaluating volunteer programs. The packet also includes resource aids and model programs.*

Welcoming and Involving New Students and Families

This aid offers guidelines, strategies, and resource aids for planning, implementing, and evolving programs to enhance activities for welcoming and involving new students and families in schools. Programs include home involvement, social supports, and maintaining involvement.*

Guiding Parents in Helping Children Learn

This aid is specially designed for use by professionals who work with parents and other nonprofessionals, and consists of a "booklet" to help nonprofessionals understand what is involved in helping children learn. It also contains information about basic resources professionals can draw on to learn more about helping parents and other nonprofessionals enhance children's learning and performance. Finally, it includes additional resources such as guides and basic information parents can use to enhance children's learning outcomes.*

IV. Technical Assistance Samplers

Behavioral Initiatives in Broad Perspective

This sampler covers information on a variety of resources focusing on behavioral initiatives to address barriers to learning (e.g., state documents, behavior and school discipline, behavioral assessments, model programs on behavioral initiatives across the country, school wide programs, behavioral initiative assessment instruments, assessing resources for school-wide approaches).*

School-Based Health Centers (7/98)

This sampler includes information on a wide range of issues dealing with school-based health centers (e.g., general references, facts & statistics, funding, state & national documents, guides, reports, model programs across the country).*

V. Guides to Practice and Continuing Education Units -- Ideas into Practice

Mental Health and School-Based Health Centers

This revised guidebook is virtually a completely new aid. The introductory overview focuses on where the mental health facets of school-based health centers (SBHCs) fit into the work of schools. This is followed by three modules. Module I addresses problems related to limited center resources (e.g., limited finances) and how to maximize resource use and effectiveness); Module II focuses on matters related to working with students (consent, confidentiality, problem identification, prereferral interventions, screening/assessment, referral, counseling, prevention/mental health education, responding to crises, management of care); Module III explores quality improvement, evaluating outcomes, and getting credit for all you do. Each module is organized into a set of units with many resource aids (sample forms and special exhibits, questionnaires, interviews, screening indicators) for use as part of the day-by-day SBHC operational focus on mental health and psychosocial concerns. A coda highlights ways to and benefits of weaving together all resources for addressing barriers to student learning into a comprehensive, integrated approach.

*You may download the indicated documents through our website at: http://smhp.psych.ucla.edu

What Schools Can Do to Welcome and Meet the Needs of All Students and Families

This guidebook offers program ideas and resource aids that can help address some major barriers that interfere with student learning and performance. Much of the focus is on early-age interventions; some is on primary prevention; some is on addressing problems as soon after onset. The guidebook includes the following: Schools as Caring, Learning Environments, Welcoming and Social Support: Toward a Sense of Community Throughout the School; Using Volunteers to Assist in Addressing School Adjustment Needs and Other Barriers to Learning; Home Involvement in Schooling; Connecting a Student with the Right Help; Understanding and Responding to Learning Problems and Learning Disabilities; Response to Students' Ongoing Psychosocial and Mental Health Needs; Program Reporting: Getting Credit for All You Do and, Toward a Comprehensive, Integrated Enabling Component.

CONTINUING EDUCATION MODULES

Addressing Barriers to Learning: New Directions for Mental Health in Schools

This module consists of three units to assist mental health practitioners in addressing psychosocial and mental health problems seen as barriers to students' learning and performance. It includes procedures and guidelines on issues such as initial problem identification, screening/assessment, client consultation & referral, triage, initial and ongoing case monitoring, mental health education, psychosocial guidance, support, counseling, consent, and confidentiality.*

Mental Health in Schools: New Roles for School Nurses

The above three units have been adapted specifically for school nurses. A subset of the nursing material will appear in video/manual self-study format produced by National Association of School Nurses with support of the Robert Wood Johnson Foundation and National Education Association.*

Continuing Education Related to the Enabling Component

Classroom Focused Enabling

This module consists of guidelines, procedures, strategies, and tools designed to enhance classroom based efforts by increasing teacher effectiveness for preventing and managing problems in the classroom and helping address barriers to learning.

VI. Feature Articles from Our Newsletter*

Mental Health in Schools: Emerging Trends (Winter '96)

Presents an overview of the need to include a focus on mental health in schools as part of efforts to address barriers to student learning. Highlights emerging trends and implications for new roles for mental health professionals. Includes tables outlining the nature and scope of students' needs, the range of professionals involved, and the types of functions provided.

School-Linked Services and Beyond (Spring '96)

Discusses contributions of school-linked services and suggests it is time to think about more comprehensive models for promoting healthy development and addressing barriers to learning.

*You may download the indicated documents through our website at: http://smhp.psych.ucla.edu

Labeling Troubled and Troubling Youth: The Name Game (Summer '96)

Underscores bias inherent in current diagnostic classifications for children and adolescents and offers a broad framework for labeling problems so that transactions between person and environment are not downplayed. Implications for addressing the full range of problems are discussed.

Comprehensive Approaches & Mental Health in Schools (Winter '97)

Discusses the enabling component, a comprehensive, integrated approach that weaves six main areas into the fabric of the school to address barriers to learning and promote healthy development for *all* students.

Behavior Problems: What's a School to Do? (Spring '97)

Sheds light on the prevailing disciplinary practices in schools and their consequences for classroom management purposes. Beyond discipline and social skills training, the article underscores the need to look into the underlying motivational bases for students' misbehavior for intervention programs to take effect.

Enabling Learning in the Classroom: A Primary Mental Health Concern (Spring '98)

Highlights the importance of institutionalizing the *enabling component* in schools. Discusses how *classroom-focused enabling* (one of six clusters of programmatic activity) enhances the teacher's array of strategies for working with a wide range of individual differences (including learning and behavior problems) and creating a caring context for learning in the classroom.

*You may download the indicated documents through our website at: http://smhp.psych.ucla.edu

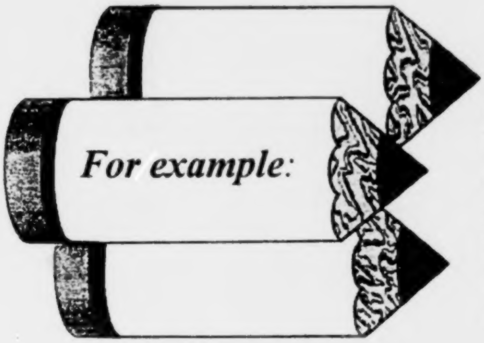
VI. KEEPING CONDUCT AND BEHAVIOR PROBLEMS IN BROAD PERSPECTIVE

Affect and related problems are often key factors interfering with school learning and performance. As a result, considerable attention has been given to interventions to address such problems. Our reading of the research literature indicates that most methods have had only a limited impact on the learning, behavior, and emotional problems seen among school-aged youth. The reason is that for *a few*, their reading problems stem from unaccommodated disabilities, vulnerabilities, and individual developmental differences. For many, the problems stem from socioeconomic inequities that affect readiness to learn at school and the quality of schools and schooling.

> If our society truly means to provide the opportunity for all students to succeed at school, fundamental changes are needed so that teachers can personalize instruction and schools can address barriers to learning. Policy makers can call for higher standards and greater accountability, improved curricula and instruction, increased discipline, reduced school violence, and on and on. None of it means much if the reforms enacted do not ultimately result in substantive changes in the classroom and throughout a school site.

Current moves to devolve and decentralize control may or may not result in the necessary transformation of schools and schooling. Such changes do provide opportunities to reorient from "district-centric" planning and resource allocation. For too long there has been a terrible disconnection between central office policy and operations and how programs and services evolve in classrooms and schools. The time is opportune for schools and classrooms to truly become the center and guiding force for all planning. That is, planning should begin with a clear image of what the classroom and school must do to teach all students effectively. Then, the focus can move to planning how a family of schools (e.g., a high school and its feeders) and the surrounding community can complement each other's efforts and achieve economies of scale. With all this clearly in perspective, central staff and state and national policy can be reoriented to the role of developing the best ways to support local efforts as defined locally.

> At the same time, it is essential not to create a new mythology suggesting that every classroom and school site is unique. There are fundamentals that permeate all efforts to improve schools and schooling and that should continue to guide policy, practice, and research.



- The curriculum in every classroom must include a major emphasis on acquisition of basic knowledge and skills. However, such basics must be understood to involve more than the three Rs and cognitive development. There are many important areas of human development and functioning, and each contains "basics" that individuals may need help in acquiring. Moreover, any individual may require special accommodation in any of these areas.

- Every classroom must address student motivation as an antecedent, process, and outcome concern.

- Remedial procedures must be *added* to instructional programs for certain individuals, but only after appropriate nonremedial procedures for facilitating learning have been tried. Moreover, such procedures must be designed to build on strengths and must not supplant a continuing emphasis on promoting healthy development.

- Beyond the classroom, schools must have policy, leadership, and mechanisms for developing school-wide programs to address barriers to learning. Some of the work will need to be in partnership with other schools, some will require weaving school and community resources together. The aim is to evolve a comprehensive, multifaceted, and integrated continuum of programs and services ranging from primary prevention through early intervention to treatment of serious problems. Our work suggests that at a school this will require evolving programs to (1) enhance the ability of the classroom to enable learning, (2) provide support for the many transitions experienced by students and their families, (3) increase home involvement, (4) respond to and prevent crises, (5) offer special assistance to students and their families, and (6) expand community involvement (including volunteers).

- Leaders for education reform at all levels are confronted with the need to foster effective scale-up of promising reforms. This encompasses a major research thrust to develop efficacious demonstrations and effective models for replicating new approaches to schooling.

- Relatedly, policy makers at all levels must revisit existing policy using the lens of addressing barriers to learning with the intent of both realigning existing policy to foster cohesive practices and enacting new policies to fill critical gaps.

Clearly, there is ample direction for improving how schools address barriers to learning. The time to do so is now. Unfortunately, too many school professionals and researchers are caught up in the day-by-day pressures of their current roles and functions. Everyone is so busy "doing" that there is no time to introduce better ways. One is reminded of Winnie-The-Pooh who was always going down the stairs, bump, bump, bump, on his head behind Christopher Robin. He thinks it is the only way to go down stairs. Still, he reasons, there might be a better way if only he could stop bumping long enough to figure it out.

We hope you found this to be a useful resource.
There's more where this came from!

This packet has been specially prepared by our Clearinhouse. Other Introductory Packets and materials are available. Resources in the Clearinghouse are organized around the following categories:

Systemic Concerns

- Policy issues related to mental health in schools
- Mechanisms and procedures for program/service coordination
  - Collaborative Teams
  - School-community service linkages
  - Cross disciplinary training and interprofessional education
- Comprehensive, integrated programmatic approaches (as contrasted with fragmented, categorical, specialist oriented services)
- Issues related to working in rural, urban, and suburban areas
- Restructuring school support service
  - Systemic change strategies
  - Involving stakeholders in decisions
  - Staffing patterns
  - Financing
  - Evaluation, Quality Assurance
  - Legal Issues
- Professional standards

……

Programs and Process Concerns

- Clustering activities into a cohesive, programmatic approach
  - Support for transitions
  - Mental health education to enhance healthy development & prevent problems
  - Parent/home involvement
  - Enhancing classrooms to reduce referrals (including prereferral interventions)
  - Use of volunteers/trainees
  - Outreach to community
  - Crisis response
  - Crisis and violence prevention (including safe schools)
- Staff capacity building & support
  - Cultural competence
  - Minimizing burnout
- Interventions for student and family assistance
  - Screening/Assessment
  - Enhancing triage & ref. processes
  - Least Intervention Needed
  - Short-term student counseling
  - Family counseling and support
  - Case monitoring/management
  - Confidentiality
  - Record keeping and reporting
  - School-based Clinics

……

Psychosocial Problems

- Drug/alcohol abuse
- Depression/suicide
- Grief
- Dropout prevention
- Gangs
- School adjustment (including newcomer acculturation)
- Pregnancy prevention/support
- Eating problems (anorexia, bulimia)
- Physical/Sexual Abuse
- Neglect
- Gender and sexuality
- Self-esteem
- Relationship problems
- Anxiety
- Disabilities
- Reactions to chronic illness
- Learning, attention & behavior problems